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INSANITIES CHARACTERIZED BY DOMINANT CONCEPTS: WITH PRESENTATION OF CASES OF AN UNUSUAL FORM.¹

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I WISH this evening to say a few words about the form of mental disease that is characterized by the continued existence of one or more dominant concepts which so influence the mental habit of the individual as to lead to the expression of fixed ideas that do not ordinarily rise to the dignity of delusions. Much has been written about this form of insanity, and it hardly seems necessary to refer in detail to the descriptions of Continental and American authorities who have given it the names of *Folie de doute*, *Grübelnsucht*, and *Insanity of doubt*, or to the exceedingly curious and bizarre actions and utterances of its victims; suffice it to say that the imperative conception that enters into the production of *doubting insanity*, as Coombes-Knapp suggests, "plays as important a part as the delusion does in the genesis of paranoia."

It is my purpose more particularly to consider the clinical features of this form of insanity, rather than the psycho-pathology of the disease, which has received ample justice, especially at the hands of Knapp, Spitzka, Krafft-Ebing, and the earlier writers. In 1885 I described the psychosis, giving it the name *introspective insanity*, and defining it as a "vague condition of mental weakness in which there is slight derangement of the intellectual powers, yet a decidedly marked enfeeblement of the will, and excitement of the emotions of a more or less limited kind." Since then various writers, although differing somewhat in their calculations, have regarded it as a low grade of *degenerative insanity*, and Spitzka calls it an "abortive monomania." Westphal and Krafft-Ebing are decided in their opinion that it is a variety of *Verrücktheit*, while American writers, among them Cowles, are not disposed to regard the affection as one due to hereditary influences. My own experience, which has been considerable, has led me to the conclusion that in the majority of patients the malady is an insanity of

evolution, and like paranoia it appears in subjects who present not only a history more or less pregnant with transmitted predisposition, but not rarely stigmata.

There are undoubtedly two forms of the disease: a respectable minority in which the persistent conceptions are limited in expression and form, and are either the exaggeration of a weakness that many normal individuals at times present, or are transient symptoms of hysteria, and often disappear under moral or medicinal treatment; and a second form which is a degenerative disease and usually incurable.

Although an attempt has been made to apply characteristic terms to mental vagaries of patients presenting this disorder, it is impossible, except in a general way, to differentiate them, although certain cases may be said to be dominated by groups of ideas, while at other times we find an association of imperative conceptions. The word "mysophobia" has been coined to designate that form in which the patient is in constant fear of contamination, and on every conceivable occasion washes his hands. "Délire de toucher," as we know, was the term applied by Le Grand de Saulle to subjects who felt impelled to touch certain objects; "agoraphobia" and "claustrophobia" to certain morbid fears of place, but like every other insanity with progress there is likely to be, sooner or later, a complex manifestation.

I have of late seen several cases that are rather unusual, for they implied a certain doubt of responsibility, or rather a fear upon the part of the subjects lest others should suffer from what they believed to be a constantly unperformed duty. This was the conspicuous feature of the insanity of an individual whose case I am about to relate, but it was connected with the mysophobia of Hammond, and a certain kind of repeated calculation, thus binding the third, fourth, fifth, and sixth clinical types of the insanity of doubt which appear in Ball's classification:

The patient was a man of thirty-five, presenting the stigmata of defective evolution. He was markedly dolichocephalic, his teeth were irregular, his forehead retreating, and his muscular motility impaired. His family history was essentially neurotic. His mother, after a life passed as an extreme fanatic, ended her days in a lunatic asylum. His father drank immoderately, and died in an asylum. One of his brothers was intemperate, and his sister was hysteric and neurasthenic, while one

¹ Read before the Neurological Section of the New York Academy of Medicine, October 13, 1893.

of his maternal uncles was also a drunkard. He had for several years been a prominent figure in the town in which he lived, and had devoted himself to prohibition, his enthusiasm being expressed in constant litigation and self-glorification. His entire life had been modelled upon plans laid down by social reformers whose teachings were bad, and marriage guides and books upon domestic medicine played a great part in shaping his home-life. In spite of his peculiarities, he is a successful business man, and has saved enough to live in comfort without helping his brothers, who are his partners, in the management of their business. His manner at the time of his visit was very hesitating and full of indecision. There was much hesitation in telling his story, and in answering my questions he repeated himself frequently. He fully appreciated his mental state, and suffered very great agony of mind and want of faith in himself.

His active mental unsoundness had lasted for several years, and began by a gradual fear of defilement from contamination. It was reasonable enough at first, and simply followed acts that naturally required subsequent resort to soap and water. But this increased so that he now washes his hands from thirty to forty times daily, and always does so after handling money. The impulses that compel him to calculate are shown almost entirely in business matters, although his habit is now to weigh all coin that he receives or gives out, and this he has done for the past two years. The question of the honesty of others does not seem to figure largely in this procedure, for he weighs the money which he gives to others and counts the bills several times, often following the recipient several times in the day to know whether the amount he has paid is correct. He carries scales with him, not daring to trust himself without them, and while admitting the irksomeness of his bondage, suffers intensely if he forces himself to place them beyond his reach. In his efforts to escape the imperative impulse, he often asks his brothers to take charge of his business, and he has finally been obliged to leave everything in their hands.

Some time ago his imperative conceptions took another form, which consisted in the belief that paper, pieces of tin, scraps of iron on the sidewalk, street, or elsewhere, would do injury for which he would be morally, if not legally, responsible if he did not remove them. Paper upon the road that might frighten horses, scrap-tin that might wound them, loose cobblestones and other objects, he would constantly gather and put out of harm's way. He was so dominated by his morbid fears and the possible consequences of neglect upon his part, that he refused to sell nails to his customers without removing the splints, and if the nuts upon the bolts he sold were loose he would screw them up. He would question purchasers as to the possible harm that might have occurred, and upon one occasion, when he went to Long Branch for his vacation, after an hour of anxiety and doubt upon the steamboat, he turned back at Sandy Hook, to remove a banana-skin he had passed without picking up on the sidewalk in New York.

His morbid fears were excited by any object which might do harm, matches, combustibles, and sharp tools being included, and he was finally obliged to seek new employment, taking charge of the bill-collecting part of the business. There was not in his case anything that might be regarded as a delusion. His relations with everyone, except the liquor-dealers, were pleasant. He slept well as a rule, but suffered from insomnia and disturbed digestion only when he underwent a peculiarly distressing period of doubt.

I have met with two examples of insanity which may be said to belong to this class, a description of which I have so far been unable to find. Its peculiarity consists in the fact that the subjects have a fixed but temporarily removable belief that certain parts of their bodies are larger than they should be. So marked is the mental derangement, and so clear-cut is its expression, that there is no reason why it should be confounded with either hypochondriac or well-marked delusional insanity. It is common to find sexual hypochondriacs dwelling upon their belief in an alleged atrophy of the genital organs, but we never find any complaint in regard to enlargement of any other part of their body. The declarations of the patients I have seen could not be accounted for by sensorial delusions, such as exist in sensorial *Verrücktheit*, because there was no difficulty in making one of them admit by reasoning that there was nothing abnormal about him. The second case, however, so closely approached actual delusional insanity, although the behavior of the patient was at first simply that of a doubting lunatic, that the case must be regarded as crossing the border-line, or approaching the extreme type of hypochondriac paranoia, for he acted upon his delusions in a very deliberate manner.

The first subject is a man of thirty-six. His father and mother had highly organized nervous temperaments, but there was no history of insanity or of intemperance in the family. He is impressionable and eccentric, although a good man of business, having charge of a large estate. He has never suffered from any special form of nervous disease, but for years he has been troubled with insomnia, and has flatulent dyspepsia. His sexual appetite has always been marked, and his fancies are extravagant. He has for many years had an idea that his hands are larger than they should be, that they are deformed, and that people are constantly noticing them. They are, in fact, of average size, not out of proportion to his height and build, and he wears a number seven-and-a-half man's glove. He rubs and feels of them constantly, compares them with those of other persons, and when riding in public places, or wherever he is likely to be the subject of observation, he hides them and eagerly watches to see whether he is the object of attention. So continually is his mind engaged in this way that he finds little pleasure in life and has practically given

up his business, and came to me after having seen many other physicians, who were unable, as I was, to reason him out of his trouble. He fully realizes the false nature of his hallucination, but is unable to antagonize the insistent idea. He has upon two or three occasions been prompted to commit suicide, because of the persistence of the mental state which he has been unable to struggle against.

The second case is one of far greater interest, because the patient has really acted upon his belief that his nose is much too large. This man consulted me about four years ago, and had been sent by his physician to see if it were possible for me to dissuade him from resorting to surgical measures which he had already arranged for. He came of nervous stock, and had all his life been eccentric and erratic, and physically showed the stigmata of a defective nervous organization. He had been known by his associates as "queer," and upon one occasion, at a picnic, had indulged in disorderly behavior and purposeless antics that were not due to alcohol, but were imperative and without meaning.

Some time before I saw him he went about among his friends, asking them whether they saw anything queer about his nose—whether it was not too large, and a number of similar questions. His friends either laughed at him or assured him of the conventional proportions of that organ, but he continued to go from one to the other, and finally sought a surgeon, who removed a piece of the septum, with some resulting reduction. However, his peace of mind and satisfaction were short-lived, and he very soon insisted that the knife had done no good. He was induced to go to his own physician, who in vain tried to dissuade him from any further attempt, and advised him to see me.

There was nothing about his nose that was at all abnormal, and its proportions, while generous, were not too great, and with this idea I strove to impress him. He not only resented my advice, but took occasion to inform me that the ears of his wife were larger, he thought, than they should be, and that after the second operation he proposed having her consult the surgeon whose aid he had previously sought.

The second operation was performed, with results which were scarcely satisfactory, and I subsequently learned that though he has so far not again adopted surgical measures, he still refers to his looking very different from other people.

The subjects of doubting insanity, according to several writers, are supposed to be chiefly women, and this has been my experience so far as the mild forms are concerned, but in those examples in which the disorder has been prolonged, the majority of patients are men. It seems to be an insanity of early manhood, and I cannot recollect a case that developed after the fortieth year. It sometimes, though very rarely, begins at puberty, but when it is found at this time of life it must not be confused with the introspection of pubescence, or the expansive insanity of youth. I have seen one case, in a

boy of nine, sent to me by Dr. Polk, who for nearly a year manifested a very profound *délire de toucher*, but this is the only case of the kind with which I am familiar which was presented before the eighteenth year.

Willie¹ reports the case of a girl about twelve years of age, whose insanity of doubt compelled her to minutely examine the things she ate, her trouble, later, taking the form of an unreasonable and constant fear that a window would fall upon her or upon someone else. There was an opening in the street which so disturbed her by reason of her anxiety and dread lest she or someone else should fall into it, that she pestered the police that it might be filled in. Whenever she saw matches she felt compelled to light them and to set fire to the draperies about her, although she knew the consequences of such an act and resisted.

Westphal² reports another youthful case, a girl of fourteen, who showed queer compelling emotions when undressing for bed. These were disorderly and explosive, and were indulged in after long hesitation and much struggle to avoid them. She was at times compelled to articulate the words "na na," and said that when she was engaged in any action she was sometimes obliged to stop precipitately, when the concept arose, and although she tried to refrain, was forced to repeat these syllables. She presented the *délire de toucher*, which afterward assumed a more insane significance, for she was compelled, according to her statement and evident sincere belief, to touch certain objects to avoid impending evil or thought. At times she would have to whisper to get rid of an unpleasant thought, and if she resisted she would become so nervous that she would scream aloud the annoying syllables.

A few months ago a boy of fourteen was sent to me by Dr. Mack, of Elizabeth, who presented a form of this disorder which I believe to be unusual, and which was due to improper religious training in a subject of defective organization. He studied hard and was ambitious, and, as a consequence, developed headaches a year ago, with indigestion and general ill-health. About two months ago his mother noticed that he washed his hands more frequently than usual, and would stand a long time before the basin in an apparently abstracted state, that he would spit in the coal-scuttle repeatedly, and that he picked up pieces of straw and matches, which were always thrown into the coal-scuttle.

He explained his actions by saying that the pieces of straw resembled crosses, and he could not show disrespect by carelessly stepping upon them. His habit of spitting, he said, was due to the fear lest

¹ Arch. f. Psych. und Nervenheilk., Bd. xii, p. 17.

² Quoted by Emminghaus.

the saliva in his mouth should interfere with the full effect of the communion-wine, and this was carried still further by spitting in his handkerchief. Of late he occasionally has delusions that his food is poisoned, but he denies this to me. When he crosses the railroad tracks that run near his house he is impelled to pick up stones that lie between the rails; if he does not do so he is filled with fear lest there may be a railroad accident.

He has all the distress of mind common to other sufferers from this form of trouble, if he neglects to follow his first impulses, and often returns to obey the dominant conception.

He often remains for a long time in the water-closet, sometimes for ten or fifteen minutes, and when his mother enters to find the reason of his seclusion, she discovers that he has littered the place with many pieces of discarded water-closet paper, refraining from desecrating by use any piece that contains creases that may bear any resemblance to the common symbol of Christianity. He examines each piece carefully. He sleeps very badly and has nightmares, and grinds his teeth. His pockets when examined are often found to contain various nails and sharp things that he has placed there after picking them up lest they might injure someone.

When I talked with him I found little or no intellectual disturbance, and I think he appeared to consider that his objections to his food were not so much because he thought it was poisoned, as because it might in some way interfere with his religious professions and duties; but from his mother's account he undoubtedly at other times has well-marked hallucinations and delusions.

He expressed much distress in regard to his condition, and I think to some extent realized its hold over him. Upon interrogation I found that whenever he walked in the street he carefully put out of the way or picked up any object, especially pieces of straw, wood, or paper, that in any way in their arrangement bore the least resemblance to a cross, for fear that he might commit some act of sacrilege.

After much questioning it turned out that he had received a deep mental impression from a story in a semi-religious school "reader," which was in use at the Roman Catholic school which he attended, and upon examining the book I found a highly-colored romance which had evidently been prepared for the purpose of appealing to impressible children of his particular faith.

As to treatment, it may be said that in the mild or hysteric cases it is often possible to effect a cure through improvement of the general health, but there is always the likelihood of a return. In these cases, as well as in those that fall under the second division, moral therapeutics are in order, and are sometimes very successful: It is of the

utmost importance that the patient should be taught to resist not only his fears but his promptings, and he should be made to do the very things that are distasteful to him, although such a course implies some mental and physical suffering. The insanity is always aggravated by yielding, and if the physician is firm and insists upon the performance of an alleged impossible act, the patient nearly always derives relief and some peace of mind from the subsequent consciousness that he has performed it. One of my patients declared she could not ride upon the elevated railroad or cross the ferry. When made to do so several times with her nurse, she frequently undertook excursions which, of course, were not attended by unpleasant consequences.

I have with difficulty hypnotized two or three subjects, and in one case in which the disorder was a light one, obtained results that were permanent by the suggestion of a state of self-reliance.

The matter of commitment frequently arises when the patient gives a history of impulsive concepts which are likely to lead to suicidal or homicidal acts. There is no rule to be laid down in regard to this, but in well-marked doubting insanity, in which *the dominant concept has lasted for some time*, I have been reluctant to send the person to an asylum, and so far have had no reason to regret my action. A step of this kind at best is a most difficult one when the ordinary intelligence and susceptibility are so well preserved. I can recall cases that have been under observation for fifteen or sixteen years, in which the patients have upon different occasions seriously referred to their promptings to use weapons for the destruction of themselves or others, but I have been able to keep the mental equilibrium at such a point that no harm has resulted.

Of course, in cases in which the existence of genuine paranoia is strongly suggested, no risk should be taken, and the patient should be promptly protected.

The mental discipline of these patients is an all-important measure, and if some formula can be devised to enable them to regulate their mental action, an occasionally striking improvement will be the result. My associate, Dr. George De Forest Smith, has had a case of sexual doubting insanity that was improved by a suggestion that the patient should keep certain hours and certain days for decision, and it was his habit, if he had a doubt, to number it, and dismiss further speculation by a kind of procrastination, saying to himself, "I will leave No. 39 to be decided on Thursday, between 12 and 1." This action of the man led him to habits of self-control in other directions, which at least have brought about much less mental torture than existed before.

**THREE CASES OF LUNG-ABSCESS—WITH
COMMENTS UPON THE ETIOLOGY,
DIAGNOSIS, AND TREATMENT
OF THE CONDITION.**

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CASE I.—Francesco Prescope, an Italian laborer, thirty-eight years of age; married; was admitted to the Buffalo General Hospital on March 31, 1893. It was impossible to obtain any history of the case. At the time of entrance the respiration was 40, the pulse 120, the temperature 102.5° F.; the tongue was coated and the appetite poor; the examination of the urine showed normality, except some diminution in amount. Physical examination revealed over the middle lobe of the right lung, behind, and in the axilla, increased fremitus, percussion-dulness, bronchial breathing, and crepitant râles; there was expectorated the sticky, rusty sputum of lobar pneumonia. The temperature continued high, with occasional marked falls for four days, when it reached 105°; the pulse ranged from 90 to 120 during this time, and the respirations from 40 to 50. From this time on, for two weeks, there was little change in the patient's condition, except as revealed by physical examination of the chest. The dulness spread downward over the lower lobe, the fremitus, râles, and finally the bronchial breathing disappeared, but the expectoration became more purulent, and finally lost entirely the characteristics of the pneumonic sputum. Finally, on April 18th (the nineteenth day after admission) the man expectorated a large amount of purulent material. Microscopic examination of the sputum (made upon several occasions) never showed the presence of tubercle-bacilli, but at this time it did show elastic fibers. Physical examination, on April 18th, showed on percussion a tympanitic resonance on the right side in the interscapular and infrascapular regions, from the lower border of the fifth rib to the eighth intercostal space. This was easily marked out by auscultatory percussion. Below this the flatness remained. Over the area mentioned auscultation revealed amphoric breathing, amphoric voice, whispering pectoriloquy, and occasionally metallic tinkling; below this area the auscultatory sounds were still absent. The diagnosis made was lobar pneumonia followed by abscess in the middle lobe of the right lung, and probably empyema.

The man was transferred to the surgical side of the hospital for operation. The operation recommended was the removal of pieces of four or five ribs, irrigation of the lung-abscess, and packing with iodoform or zinc-oxid gauze. The operation performed was the resection of a portion of the fifth rib and drainage. After this operation the patient improved for a while; but, in spite of frequent dressings and, also, finally, a counter-opening lower down in the chest and thorough drainage, the temperature continued its diurnal rise and fall, and the patient had all the appearance of one suffering from pyemic poisoning. At length, on July 14th, the operation was com-

pleted, and one and a half inches of the sixth, seventh, and eighth ribs were removed, in addition to the section of the fifth rib that had been removed at the first operation. The abscess was irrigated and packed with zinc-oxid gauze. For twelve days thereafter the temperature varied from 98° to 101°. The man was discharged from the hospital, entirely well, September 30th. I was not notified when he was to be discharged, and so was unable to note the condition of the lung, and there is no memorandum in the surgical records as to this.

CASE II.—Refrigealo Cristeizo, an Italian, thirty-four years of age; a laborer; single; entered the Buffalo General Hospital June 8, 1893. His temperature was 101°; pulse, 130; respirations, 38. I saw him the next day and found the same rate of respiration, temperature, and pulse, the last being small and weak. Physical examination showed the right side bulging and motionless, without fremitus. On percussion, absolute flatness was found all over the right chest, in front and behind; on auscultation there were no breathing-sounds or voice-sounds. The heart was displaced to the left; there was a systolic bruit at the apex, and a diastolic bruit over the aortic valve; the pulmonary second sound was markedly accentuated. The diagnosis was pyothorax of the right side, so extensive as to cause complete compression of the lung. The dyspnea was so marked—amounting to orthopnea, the respirations rising to 44 per minute—that I advised immediate aspiration of part of the fluid to relieve this condition. Eighteen hundred cubic centimeters of cloudy, greenish, puruloid fluid were withdrawn by the aspirator, and the patient was then transferred to the surgical ward. Two days later the man was operated on by Dr. Phelps. One and one-half inches of one rib (which rib not noted) were resected, and 3000 c.c. of pus were removed and the cavity drained. At the time of this operation it was found that there was direct communication between the lung and the pleural cavity, but the extent of destruction of lung-tissue was not investigated.

After the aspiration, June 9th, the patient's general condition improved, so that on the day of the operation the temperature had reached normal, the pulse had fallen to 80, and the respirations to 30. For two days longer the condition remained about the same, but on the third day the temperature rose to 103°, falling to normal, and rising the next day to 102°, again falling to normal, and then rising to 106°. It kept on in this manner for eight days, moving from a morning record of 99° to an evening record of from 102.5° to 104.5°, the respirations at the same time ranging from 30 to 45 per minute. The temperature then ran along for five days below 101°, but still showing the marked breaks of sepsis. On the morning of July 1 the temperature was 97°, and eight hours later 104.8°—a range of nearly 8° in eight hours. From this time the temperature kept up the diurnal range from 97° to 100°, or 101°, or 102°, with a leap every third, fifth, or seventh day to 103°, 104°, or 105°. The pulse kept ranging from 100 to 140, reaching 160 some eight hours before death. The

respirations ranged most of the time from 30 to 40, occasionally rising to 50, and five hours before death reaching 80. The patient died on July 17th, thirty-six days after operation. It was impossible to procure an autopsy.

CASE III.—William Croll, an American, fifteen years of age; a clerk; was admitted to the Buffalo General Hospital on September 1, 1893. Appendicitis was diagnosed, and the patient was transferred to the surgical ward with advice for operation, which was performed on October 11th, resulting in the evacuation of a large abscess, containing 200 c.c. of thick, creamy, ill-smelling pus. The abscess extended down into the pelvis. In addition to the pus there were removed from the cavity the appendix vermiformis and a mass of new fibrous tissue, half an inch thick and three inches long. In spite of this operation, and although the local condition improved daily, the patient's general condition showed evidence of pyemia, and the temperature-curve showed the characteristic rise and fall. On October 28th the patient began expectorating bloody pus, which did not contain tubercle-bacilli. On October 30th, at Dr. Parmenter's request, I examined the patient's chest. Inspection showed diminished respiratory movement on the left side; palpation, increased fremitus in the infraclavicular and upper part of the interscapular region, absence of fremitus in the lower part of the infrascapular region, a peculiar fremitus in the lower part of the interscapular and upper part of the infrascapular region. On percussion, skodaic resonance was obtained in the infraclavicular region, slight dulness in the mammary and upper axillary region, slight dulness in the suprascapular and upper part of the interscapular region, dulness in the lower part of the interscapular region, gradually increasing until flatness was attained in the lower three-fourths of the infrascapular region. On auscultation, exaggerated breathing was found on the right side, diminished breathing of a broncho-vesicular type over the upper part of the left lung, in front and behind, accompanied by moist râles; in the lower part of the interscapular and upper part of the infrascapular region, near the spinal column, cavernous breathing was found of peculiarly amphoric quality, changing, as the stethoscope moved downward, to distant bronchial breathing, and then ceasing altogether; egophony was also heard at the junction of the interscapular and infrascapular regions; and below this the voice sounds were absent. The diagnosis was empyema, with probable lung-abscess.

The operation took place on November 1st. From one and a half to two inches of the sixth rib were removed at the posterior axillary line, and about 800 c.c. of bloody pus evacuated. An evident opening into the lung was present, though the situation and extent of loss of lung-tissue were not investigated. The cavity was drained. The condition of the patient after operation was as follows: The temperature varied from 99° to 101°; the pulse from 90 to 100; and the respirations from 25 to 30. Physical examination on November 7th showed the presence of pus in considerable amount, and poor expansion

of the lung; the opening from the lung into the pleural cavity was still present. There was poor drainage from the opening in the chest. On November 23d, the temperature had not been above 99.5° for a week, and the pulse had ranged from 80 to 90, the respirations averaging about from 25 to 30; the patient's general condition was markedly improved, the appetite good, and the bowels regular. He has gained in flesh, though very anemic, and is up and walking about the ward. Physical examination of the chest shows a tendency to droop to the left, both shoulders falling forward, and the chest being quite flat, with considerable spreading out in the hypochondriac and lower axillary regions; there is relative fulness of the left supraclavicular and infraclavicular regions, respiration rapid and shallow. Upon forced respiration fair expansion of the supraclavicular and infraclavicular regions is found on both sides, and poor expansion in the left hypochondriac and axillary regions; posteriorly there is very slight movement of the left side, with marked expansion of the right side. Fremitus is good everywhere, except in the infrascapular, axillary, and hypochondriac regions of the left side, where there is none to be felt. There is hyper-resonance in the left supraclavicular and infraclavicular and suprascapular regions, slight dulness in the left interscapular and hypochondriac regions, marked dulness amounting almost to flatness in the left infrascapular and lower axillary regions, and good resonance all over the right side. On auscultation the breathing sounds are found to be good over both apices, slightly diminished in the left axillary and hypochondriac regions; posteriorly there is exaggerated breathing upon the entire right side; on the left side diminished breathing in the suprascapular, scapular, and upper part of the interscapular regions; there is bronchial breathing in the lower part of the interscapular region, and absence of breathing in the infrascapular region. Vocal resonance is diminished all over the left side in front and behind, except in the infrascapular and lower axillary regions, where there is none.

As to the heart, the apex is in normal position, the action weak and hurried, the first sound relatively weak, the pulmonary second sound accentuated; the wound in the side is closed, but is not skinned over, there being present an exuberant growth of granulation-tissue.

Of these three cases, the first was proved to be one of pulmonary abscess, and is of special interest from an etiologic point of view, as it was a definite case of lobar pneumonia terminating in abscess and final recovery. Of this condition Fagge says: "The formation of an abscess in the lung-tissue as the result of true pneumonia is admitted by all writers to be very rare. So far as my own observations have gone I am quite disposed to agree with those who doubt whether it ever occurs."

Of abscess of the lung following lobar pneumonia, Flint says: "The collection of pus in an abscess leads to a sudden and copious purulent expectoration, if the life of the patient be sufficiently pro-

longed, and the existence of a cavity may be determinable by physical signs. This is a grave event, but it by no means necessarily renders the disease fatal. It occurred in four out of one hundred and thirty-three cases which I recorded and analyzed, and two of these four cases ended in recovery."

Osler says: "Abscess may result from purulent infiltration of lung-tissue. It occurred in four of my one hundred cases (autopsies). Usually the lung breaks in limited areas, and the abscesses are not large, but they may involve a considerable portion of a lobe."

As regards etiology Osler says: "Suppuration occurs in the lung under the following conditions: 1. As a sequence of inflammation, either lobar or lobular; after lobar pneumonia it is extremely rare; on the other hand abscess-formation is extremely frequent in the deglutition and aspiration forms of lobular pneumonia." (Possibly our second case may have had some such origin.) "2. Embolic, so-called metastatic abscesses, the result of infectious emboli, are extremely common in a large proportion of all cases of pyemia." (Our third case was undoubtedly one of this class.) "3. Perforation of lung from without, whether from external injury or perforation of abscess from below. 4. Tuberculosis."

The diagnosis of abscess of the lung is not difficult if one bear in mind the etiology, and follow closely the clinical developments of his cases.

In any case of lobar pneumonia which does not run a typical course, the possibility of termination in abscess should be borne in mind, and its development watched for. Septic fever, change in the character of the sputum to pus or bloody pus, rapid or sudden increase in amount of the sputum, and the physical signs of cavity, indicate lung-abscess. In the physical exploration of the chest I wish to lay especial stress upon auscultatory percussion as a most important procedure in the diagnosis of the existence and the extent of the abscess.

In all cases of empyema the possibility of the coexistence of lung-abscess should be borne in mind and the condition looked for. My third case illustrates this condition. Which was primary in this case it is absolutely impossible to say, but there is greater probability of an abscess breaking from the lung into the pleural cavity than from the pleural cavity into the lung, although the latter event does sometimes occur. In all cases of suppurative disease in any part of the body the supervention of respiratory difficulty should call for immediate examination of the thorax; even when there is no apparent respiratory disturbance in such a case, the continuance of the febrile symptoms after the evacuation of pus from the original seat of disease should call for a rigid examination of the entire

body, including a careful physical examination of the chest to determine, if possible, the situation of any collection of pus. Having determined the existence of an abscess in the lung, the matter of treatment next confronts us. It is possible that certain cases may recover after evacuation of the abscess spontaneously through a bronchus (I believe the two recoveries mentioned by Flint occurred in that way), but by far the best practice is to open through the chest-wall into the pleural cavity, and thence into the lung, if the opening from the lung into the pleural cavity has not already occurred spontaneously. The opening into the chest-wall should be made sufficiently large to allow the extent of injury to the lung-tissue to be discovered, and to allow of thorough irrigation of the abscess-cavity and of the pleural cavity; then the abscess should be packed with zinc-oxid gauze or with iodoform-gauze and zinc-oxid gauze, the dressing to be changed as frequently as necessary. I think if the primary operation in the first case reported had been as thorough as it afterward had to be made, the second and third operations would not have been needed, and the case would have recovered much more quickly. I think that if the operation in the second case had been as thorough as indicated, the patient would probably have recovered, for he lived for a month after the imperfect operation. The result in the third case shows either that the opening from the lung into the pleural cavity was very small, or that occasionally a case of lung-abscess may recover after simple drainage. However, even in this case the present condition of the left chest, as shown by physical examination, is one in which the lower part of the pleural cavity has become so filled with granulation-tissue that the lung cannot expand there. It seems to me that there would have been greater probability of healing, with less granulation-tissue, if the original operation had been extensive enough to allow thorough drainage and antiseptic treatment of the interior of the abscess.

The *rationale* for a thorough operation in cases in which there is an opening present between the lung and the pleural cavity is this: By removal of the fluid from within and around the lung the capillaries of the lung are opened up and their absorptive power rendered most active; if now the external opening is not sufficiently large to allow thorough drainage to take place, and the parts are not rendered clean by irrigation, the absorption of septic material into the circulation must be extensive and the patient's condition rendered really worse than before operation; if, however, a sufficiently large opening is made and thorough drainage established, the abscess-cavity can be rendered as nearly aseptic as possible by packing with anti-

septic gauze, and thus the patient's chance for recovery is made immeasurably better.

These statements are thoroughly borne out by the course of the first case cited. The first operation was the removal of a part of one rib and the establishment of poor drainage; the septic condition continued and grew worse; the second operation was the making of a counter-opening lower down in the chest, with irrigation and the establishment of thorough drainage of the pleural cavity; the patient's condition was slightly improved for a time, but septic poisoning returned with great vigor; the third operation was the removal of pieces of four ribs, thorough irrigation, and aseptic packing of the lung-abscess, and the result was recovery.

The special point that I wish particularly to emphasize is that in all cases of empyema in which an opening from the lung into the pleural cavity is present, enough of the chest-wall should be removed to enable the operator to investigate thoroughly the nature of the opening and learn the amount of destruction of lung-tissue. In this way if it prove to be an abscess, it may be treated as an abscess should be treated in whatever part of the body it may occur.

THE INCISION IN ABDOMINAL SECTION: HOW TO CLOSE IT, AND ITS POST-OPERATIVE COMPLICATIONS.

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THE question that most vitally concerns us in our surgical and gynecologic work is: How can we reduce the mortality? The question is a momentous one, when it is considered that it is human life we deal with; that our surgical judgment and surgical fingers repeatedly determine the issue of life or death. Our progress, the victories gained, are gratifying but not satisfying. We go back only for the lessons of skilled experience, to get in more intimate touch with the teachings of those who blazed the way for us against the superstitions and prejudices of ignorance. It was not within the human limits of the honored pioneers of our profession to drive out all the darkness and let in all the light, nor will it be within ours.

While the ignorant mob may not be at our doors clamoring for blood in atonement for our real or imagined failures, there is a malign power still not broken, throned about educational centers, scattered everywhere, and to our humiliation finding mischievous allies in the ignorant, prejudiced, and unscrupulous of the profession. They are the men who embarrass advanced teaching, who place in the way of the progressive, conscientious, and practical teachers their chief obstruction and discouragement.

The man who cannot or will not learn should practise at least the virtue of silence. Not a few of the afflicted suffer premature death, or live useless lives, live through years of avoidable suffering, through ignorant and pernicious intermeddling.

We refer to our surgical advances as marvellous. In a strictly modern sense they have been so, yet half a century elapses between McDowell, Bernham, and Mr. Tait. The Atlees, with their sound surgical judgment, their masterly surgical skill, and their high professional honor, come in early and make profitable history for the surgeon's reading. With our better perfected methods we are fortunate in the possession of the advantages of the lessons the wisdom and courage of these men evolved and mastered. A glance at our own field faintly conveys to us some realization of the embarrassments with which they contended. They did that which made it possible for us to be where we are: they made an intelligent beginning. We cherish the faith that they transmitted, to men of our own day and generation, some of the mettle which gave them their triumphs.

Let us begin where our surgery begins—with the incision. We have nothing from which we can even approximately determine to what extent the length of the incision influences the mortality. The statistics of comparative results would not prove satisfactory for the reason of the entry of so many other compromising elements—for example, adhesions, their character, extent, and locality. That the length of the incision exercises a greater influence than is generally recognized or admitted, I entertain little doubt.

As to length, no rule of mathematic certainty can be laid down. In my own experience I find the balance of both convenience and safety to lie with the short incision. Muscle undamaged and intact is the material and best protection to the abdomen, and there is less bleeding when it is uncut. A short incision narrows the limits of hemorrhage. However simple may be the structures composing the abdominal walls, a lengthy incision gives unnecessary extent to exposure of the peritoneal cavity and the abdominal viscera to atmospheric influence, and to needless contact with the hands of the operator—and this without lessening the difficulty in dealing with those varying emergencies constantly encountered by operators. It is safe to begin with a small incision, and when the size and character of the tumor or complications present require a longer one, it can easily be made. Very much of our abdominal work can be done through an opening admitting only two fingers. The reliance of the abdominal surgeon must be largely in educated fingers. Diseased tissues may be dealt

with through a small incision; exposure of adhesions to view is not necessary, except those of the small bowel. In a majority of cases an operation can be done through a small incision without the operator or spectators seeing the viscera. Universally adherent, irreducible, or solid tumors, require a long incision for delivery, and for dealing with complications that can only be dealt with through the long incision—those beneath and on the sides of tumors. In the majority of cases to so enlarge the opening as to obtain a view of the parts augments the risk of ventral hernia and provokes tedious convalescence.

The question as to the length of the incision continues a controverted one, and the opinions of those who by reason of their experience are entitled to speak with some weight of authority, have for us a practical interest, though we may not accept them for our guidance. Peaslee, in his excellent work on ovarian tumors, in referring to the controversy that arose in England between the advocates of the long incision and those of the short one, says: "It is sufficient for my purpose to state that by the short incision I mean one from three to six inches long, and by the long incision one of ten inches or more, and sometimes extending from the symphysis pubis to the ensiform cartilage, as practised by Dr. Charles Clay." Quoting Kœberle, he says: "In his first 69 cases the mortality was directly proportional to the length of the incision. He found that of 12 cases in which the incision was from two to four inches, only one died; of 48 cases, with a length of from four to ten inches, 15 (one-third) died, and if the incision was from ten to sixteen inches, 8 out of 22 died." But Kœberle, unlike Dr. Clay, adopted the long incision only when obliged to do so. In his first case of ovariectomy Dr. McDowell made an incision nine inches long. He said of his operations: "My incisions were always so free and extensive that I always performed every part by sight." Dr. Nathan Smith in his first ovariectomy (1821) made an incision three inches long and successfully removed an ovarian cyst through the incision. The early advocates of the short incision regarded all incisions as short that did not exceed six inches. Peaslee lays down the following practical rules:

"1. To make the opening into the peritoneal cavity for the removal of the tumor at least three inches long to begin with, and, of course, longer in case of large cysts which cannot be essentially diminished by tapping; and

"2. Then to prolong it, if necessary, and only so far as is actually required."

He illustrates as follows what is meant by long and short incisions, and, in his view, their relative dangers: "Making the distinction of (1) very short

incision, two and a half inches and less—and such alone was really meant by the operatio minor; (2) short, three to six inches; (3) long, six to ten inches; and (4) very long, ten inches or more—operatio major." Their relative danger may be pressed as follows:

Very dangerous.	Less dangerous.	Comparatively safe.	Very safe.
Very short, two and a half inches or less.	Very long, over ten inches.	Long, six to ten inches.	Short, three to six inches.

The bad results of German ovariectomists, when they have been bad, cannot be logically or justly credited to the short incision; when they have failed, their failures are to be credited to other causes, chiefly to dirt. Their recent work has been good.

I repeat that my own experience does not accord with the experience of the advocates of the long incision. I cannot, therefore, accept the opinion that a short incision is dangerous. Through a small incision—except in cases of large, irreducible, or solid tumors, of course—there can easily be conducted all needed manipulation of parts, thorough explorations for adhesions and their safe detachment, and a careful cleansing and flushing of the peritoneal cavity.

When the one idea, that of safety, dominates all others, every precaution will be used to prevent accident in any form. The importance of a perfect closure of the incision has only recently received the attention that it deserves. The effort should be to approximate as nearly as possible normal conditions, anticipating and dealing with all existing or possible complications with scrupulous minuteness and care, thus guarding against those accidents that are too frequent. It is true that some of our bad results are beyond our explaining and beyond our avoidance, but there are many accidents for which we have no valid excuse. In the major number of our cases we can account for the accidents from which our patients suffer and with which we have to deal; we can trace the trouble very generally to the manner in which the operation was done—to bad, incomplete, or too much surgery.

For a long time the closure of the incision was a matter of rude surgery; transfixion-pins, with figure-of-eight strings thrown about them, constituted a common method. I do not pretend to suggest uniform procedures for all cases; each operator has his own way, and does his own work best in that way, and without special training it would not be possible for him to apply the methods of others safely and successfully. I am satisfied that the exposure and manipulation of the incision, as well as

the peritoneum, is harmful. Incisions bathed in pus and filth, and freely manipulated, often refuse to unite. The incision is an outward, a surface sign of our workmanship, and we should have some pride in its character; it should not be a sign of mutilation. An extensive incision, one indicating careless, slouchy, indifferent surgery, is something more than a discredit to the surgeon; it is a continuous annoyance to the patient.

Careful study and effort should be made to avoid the presence of cicatricial tissue. Strenuous endeavor should be made to secure primary union in all wounds. Suppurating wounds are largely due to careless closure or to tight sutures including too much tissue; tight suturing is too common, and in many feeble subjects has destroyed life. Suppuration due to tight suturing and stitch-hole abscesses in all sections prolong convalescence when they do not result fatally.

The now-fashionable buried suture is not free from danger; nor is this method carried out by any material giving the perfect result claimed for it. In two cases I have repeated operations on the same patient to remove the entire scar. These two patients came to me with scars studded all over with sinuses; in one I feared sarcoma of the scar, but, after removing the large diamond-shaped piece underlying the entire width and length of the scar, I found upon careful dissection numerous ligatures or buried sutures throughout its entire center. Through the many years of suture-experiment the application of the buried suture at any and all points of the body has been found a failure. The use of the silver ligature in ovariectomy has been followed by abscess and death. The buried suture in the female perineum is also followed by suppuration. Human tissues will not tolerate the presence of a non-absorbable foreign body. Undue chances and liberties should not be taken with the peritoneum because of its great tolerance.

That eminent old English surgeon and author, Richard Wiseman, as far back as the reign of Charles II, more than two centuries ago, wrote, under the caption of "Wounds of the Belly": "Authors have proposed several ways of stitching these wounds which I shall not trouble you with, but advise you to make your stitches deep, that the peritoneum may be united with the flesh; for if you fail therein a hernia must necessarily succeed." Through-and-through suturing, including all structures, more of the central structure than skin or peritoneum, with either silkworm-gut or pure silk, two of the strongest and cleanest of all materials known, have given and continue to give the most satisfactory results. Silkworm-gut seems to be the favorite material at present; it possesses all the natural and essential qualities of a suture, is small,

strong, and non-irritating—the three cardinal virtues of all good suturing material. The method of terracing sutures has nothing to recommend it, while it prolongs the operation, which is an important consideration in all cases in the hands of young operators, who under the stress of the occasion are likely to forget the results of a careless and needlessly prolonged anesthesia. Retraction of skin and peritoneum by the introduction of silkworm sutures gives inclusion of more central structures and the least possible tension on skin and peritoneum.

To so introduce sutures as to secure the desired results requires practice with a fine, straight needle and the education of the fingers. By such methods it is exceptional to have cutting sutures or stitch-hole abscesses. In tying the sutures you will find muscle and aponeurotic structures in apposition before the skin approximates. Keith, Tait, and Bantock all use the fine, straight needle; their work has been about perfect. The use of large curved cutting needles is harmful, as they favor hemorrhage and, secondarily, stitch-hole abscesses. In anemic patients the Hagedorn needle favors hemorrhage; it has a cutting edge of quite one line in length. Too much emphasis cannot be placed upon the use of silkworm-gut sutures, introduced three or four to the inch, including all the structures of the abdominal wall. The use of uncertain material like cat-gut or tendon is a mistake, as, if one rely upon the manufacturer, he is never certain of its purity or quality. The surgeon should cleanse and prepare his own materials if he would do good work.

To minimize post-operative complications and the discomfort of the patient all operations should be done rapidly, through the smallest possible incision. Existing adhesions, omental and bowel, should be freed, the finest and purest of silk and the least quantity consistent with safety should be used; heavy, coarse material, silk or other, should not be used. Viscera should be placed in normal position and the incision closed after careful drying. Dry dressing with a snugly-fitting bandage is sufficient. I have given all methods of suturing the abdominal wall a faithful trial. I have also watched the methods and results of others, and again in re-operations in removing scars I have made careful studies, that I might determine the best. The deductions of my experience confirm me in the use of the methods and material I have suggested.

The operation of hysterectomy differs from ovariectomy in requiring a very much larger incision, because the tumor is solid. Mr. Keith says:

"I do not think that the length of the incision influences much, if it influences at all, the result in hysterectomy. The closing of the large wound prolongs the operation, but the after-comfort of the patient is in no

way affected by the length of the incision, if proper care be taken at the time to close the wound very accurately by a sufficient number of deep sutures. Of these I put in about four to the inch. Where the wall is thin, as it generally is, about the umbilicus a larger number may be required. I have put in a great number of sutures, and I think I put in twice as many as anyone else, and take in the whole deep tissues of the wall. I have seldom had to see a patient on account of any discomfort arising from the wound. There is no greater mistake than to include only the skin and peritoneum (this is Spencer Wells's method). It saves trouble at the time, perhaps, but in a month or two the patient suffers. It is said that the cicatrix comes to this in the end in all cases. It does not; with a properly united wound, with a sufficient number of deep sutures, taking in all the tissue, no hernia ought to happen."

Dr. John Homans, of Boston, in his little book reporting his work, says:

"The usual length of my incision is about two inches, except in fat people, or when some difficulty in the operation requires more room. I have always used silk sutures, and am careful to include all the abdominal parietes in the suture, particularly the transversalis fascia."

To the following recommendation by the same author we most decidedly object: "During convalescence the patients have found the lifting-machine, figured in Hamilton's surgery as Dr. Jenks's fracture-bed, very useful, portable, light, and strong." I object to whatever involves the risk of strain upon the muscles. Strain is one of the chief causes of hernia. Machines strain, and when they are used no one need be surprised to find that 30 women out of over 300, or nearly 10 per cent., have ventral hernia."

The old principle of rest, position, and pressure is as valuable in special as it is in general surgery. By rest I mean absolute lying on the back for days, limited only by the necessities of the case—the condition of the patient. For the first day it may seem irksome, but the patient, under kind and attentive nursing, soon rallies from this sense of irksomeness. Patients turned early, as a rule, do badly, and their incisions often give trouble.

DIPHTHERIA: PRIMARILY A LOCAL, SECONDARILY A CONSTITUTIONAL DISEASE.

BY W. CARROLL CHAPMAN, M.D.,
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PEPPER, 1893, says: "The majority of authors are still agreed in calling diphtheria a general or constitutional disease which develops a local lesion at some period of its course, though many are inclined to advance the opinion that in *exceptional* cases the local lesion may first appear."

Yeo, 1893, says: "It has been established that it (diphtheria) is primarily a local disease, a local infection, and that the constitution is secondarily affected by the absorption of toxic substances de-

veloped by the activities of a specific micro-organism at the seat of local infection."

Microscopy has been the principal means of real advancement in this subject, but there are more ways than one to arrive at a positive conclusion in the majority of cases. As an illustration we might allude to a case in which syphilis is suspected, the history obscure, the initial lesion not well marked, and the eruption so slight as not to have been noticed, and yet, later, symptoms manifest themselves of a serious character, which quickly yield to syphilitic treatment and to no other. In such a case we are justified in a diagnosis of syphilis.

By the same manner of reasoning we are sustained in the conclusion that diphtheria is primarily a local and secondarily a constitutional disease. In support of this claim I will briefly relate the following nine cases and the *treatment or not* of the *other* children in the families exposed.

FAMILY NO. I; CASE I.—On November 22, 1892, I saw V. S., ten years of age, whose tonsils had been enlarged since infancy. I found the pharynx and tonsils inflamed and tumefied; the temperature 104°, the pulse 120, and the cervical glands enlarged. I pronounced the case one of tonsillitis, and ordered treatment accordingly. On the third day the symptoms were not being allayed and the child was in a stupor, with mouth-breathing. Inspection was made, and a diphtheric membrane was noticed on the tonsils and muscles of the pharynx. The membrane was well marked, as was also the peculiar musty and fetid odor of diphtheria. I immediately placed the patient on potassium chlorate, tr. ferri chloridi, and stimulants; I also used a spray of hydrogen dioxid and water, equal parts, in the throat and nose. The other rooms of the house were thoroughly fumigated with sulfur, and the two other children were separated from the patient. Communication between parents and children could not be prevented.

On the fourth day the temperature was 102°, the pulse 110, with complete obstruction in both nostrils, and in them membrane plainly visible. The foregoing treatment was continued for five weeks, except that as the case improved the H₂O₂ was diluted by four or five parts of water. The temperature ranged from 100.5° to 102° until convalescence became established.

CASE II.—Four days after the appearance of membrane (seventh day of disease) in Case I, a sister, aged eight years, was taken with an inflammation of the pharynx and tonsils. The temperature was 104°, the pulse 120. On the second day whitish patches made their appearance, which on the third day developed into the diphtheric membrane with all the symptoms of diphtheria—mouth-breathing, enlargement of cervical glands, fetid odor, and stupor—the membrane in this case also reaching into the entire nasal cavity. On the first appearance of the disease the same treatment was begun as in Case I—potassium, iron, whiskey, and antiseptic spray—and continued to convalescence.

CASE III.—The youngest sister, aged six years, was taken with the same symptoms on the sixth day after the appearance of the membrane in Case I. The disease developed and was treated in the same way as in Cases I and II, to convalescence. Each child was treated, from the time of the commencement to dismissal, for about seven or eight weeks. All recovered, the symptoms never becoming graver than those of the first three days after the appearance of the membrane, except a sinking spell in the youngest about the fifteenth day. This was treated by increase in stimulants, the patient rallying in about eighteen hours.

FAMILY NO. 2; CASE IV.—October 21, 1893, J. W., aged eleven years, had been sick for three or four days when I was called. Examination of the throat revealed diphtheric membrane. The temperature was 103° ; the pulse 108; there were present cervical enlargement and all other symptoms of diphtheria. I fumigated the house with sulfur and excluded the other children from the patient's room. The same treatment was employed, except the whiskey, as in the three cases already narrated.

CASE V.—Four days later the younger brother, aged four years, was taken ill with the disease. The same treatment was carried out.

CASE VI.—Two days later, or six days after the first case in Family No. 2, the next oldest boy contracted the disease. In Cases IV and VI the membrane formed in the nose also; in Case V it did not. The baby, nine months old, escaped. The disease was light, lasting only thirteen, ten, and fourteen days respectively. The same treatment was used.

FAMILY NO. 3; CASE VII.—A. S., four years of age, was taken ill October 25, 1893. The temperature was 104° , the pulse 126, the pharynx red; there was stupor, cervical enlargement, and vomiting. I gave a cathartic with bismuth and carbolic acid. On the third day white patches appeared in the pharynx, which developed into well marked diphtheric membrane on the fourth day, with all the symptoms of diphtheria. I fumigated the house, and separated the child from the other two children, and with a second atomizer had their throats and noses sprayed twice daily with the same antiseptic, diluted with five parts of water. They escaped the disease, although Case VII was well marked. The same treatment was used as in the other cases reported, extending over a period of twenty-one days, with recovery.

FAMILY NO. 4; CASE VIII.—V. G., ten years of age, was taken ill on October 30, 1893. She had been sick four days when I was called in. The diphtheric membrane was well developed in the nose and throat, as were all the symptoms of the disease. The temperature was 103° , the pulse 120. Iron, potassium, stimulants and the antiseptic spray were ordered. On the second day, the fifth of the disease, the temperature was 98° , the pulse 100 and feeble. I increased the stimulants. There were nausea and vomiting. The temperature ranged from 97.5° to 100° until the thirteenth day, when the child became worse, the temperature 97.5° , the pulse 140 and feeble. I then gave digitalis. The membrane

had now about cleared away; the child rallied for a few hours and died suddenly from heart-failure. The brother, two and one-half years old, was permitted to be in the same room all through the illness, but his throat was sprayed with a solution of H_2O_2 , 1 to 5, daily, without symptoms of the disease arising.

FAMILY NO. 5; CASE IX.—M. M., six years of age, on November 12, 1893, had been sick four days when I was called. I found diphtheric patches appearing, and the patient almost completely overcome by the intensity of the poison. I ordered stimulants, iron, potassium, and the spray. On the second day the membrane was well developed, but the symptoms were allayed, and continued so until the twelfth day of the disease, when the spray was left off and the patient became worse. The spray was recommenced, with alleviation of the symptoms, and was continued to convalescence.

Here we have nine well-marked cases of diphtheria, with one death—a mortality of about 11 per cent. Before using this treatment, with especial attention to the spray, I am ashamed to say the mortality of my cases was about 75 per cent., although I had used the potassium, iron, and stimulants, with other local applications mentioned, brushed or blown on the surface.

The result of the observations upon these cases points to the following conclusions:

1. Diphtheria is manifested locally first, the disease being often overlooked until the constitutional symptoms appear, these being caused by the absorption into the system of the toxic albumin given off by the Klebs-Loeffler bacillus.

2. The bacilli forming the toxic albumin are located in the larynx, pharynx, or nose, because the symptoms of poisoning by them are allayed when the proper germicide is thoroughly applied to these mucous membranes.

3. Even if the bacilli are situated beneath the surface, a solution of H_2O_2 , and probably of other antiseptics, has the power of reaching them.

4. Constitutional symptoms appear to be prevented when the germicide is applied, at intervals of two hours, before absorption or secretion of the toxic albumin has taken place.

5. It seems clearly proved that the bacillus first attacks, at least in a large majority of cases, the membrane of the throat and nose exclusively, as those children exposed to the disease but whose noses and throats were treated with germicide daily during exposure, did not contract the disease, while those not so treated, except in one instance, did contract it.

6. Hydrogen dioxide, and probably mercuric chlorid, and some other germicides, in proper solution, have the power, when applied to the bacilli, to render them inactive and probably to destroy them, thus preventing secretion of the toxic albumin.

In support of this claim attention is called to Case IX. When the spray was left off on the twelfth day, at a time when the membrane had not entirely left the post-nasal space, there was a re-appearance of the toxic symptoms. It might also be well to state that in Case VIII the atomizer broke ten or twelve hours before death and the spray was not introduced well. In several cases now under my observation, with the same treatment, the same results are being obtained.

The number of cases here detailed may be too small to definitely prove the conclusions drawn, but they strongly support the position taken, and further observations in this line will likely establish the fact.

A NEW METHOD OF TREATMENT OF CHRONIC NASO-PHARYNGEAL CATARRH.

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SEVERAL years ago, after relieving a number of patients of dacryo-cystitis by syringing the sac and nasal duct, the patients stated that they were also relieved of their chronic naso-pharyngeal catarrh. This fact suggested investigation, and patients without symptoms of disease of the tear-passage who had naso-pharyngeal catarrh were treated by syringing this passage. More than fifty patients have been thus treated with benefit during the last two years. The following two cases were typical and received no other treatment.

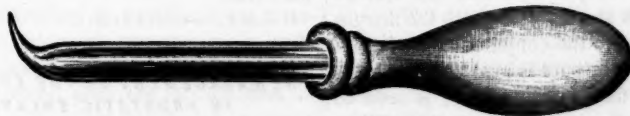
CASE I.—Mr. R., forty-one years of age, began treatment October 16, 1891. He had had chronic naso-pharyngeal catarrh for twenty years. There was considerable hypertrophy of the turbinated

could remember. The mucus in his throat was profuse, thick, tenacious, and much worse in the morning. Efforts to clear his throat in the morning as a rule excited nausea and vomiting, so much so that he had never been able to eat any breakfast. He had hypertrophy of the turbinated bones, the right side being much worse than the left. For a number of years he had had hemorrhages from the right side of the nose, occurring at least twice a week, and lasting from two to eight hours. He was also a great sufferer from headaches, which were aggravated by frequent "colds" in the head. Ten years ago he was treated by cleansing and astringent sprays, and obtained some relief, which was only temporary.

Syringing the tear-passages with solutions of salt and water and nitrate of silver, gr. j to ʒj, gave some relief. Syringing the tear-passages with sweet oil gave greater relief, and treatment three times a week for three months was followed by apparent cure.

On October 1, 1893, more than twelve months after cessation of the treatment, the patient stated that he still felt relieved, and he has had no hemorrhages from the nose. Both sides of the nose seem clear. There is no mucus in the throat. He has not been troubled with nausea or vomiting. For the first time in his life he has enjoyed his breakfast every morning. The headaches have not returned, and he has had no colds in his head.

The syringe used is the ordinary glass eye-dropper with the tip drawn out to a fine point, and is made by Messrs. Kellogg & Co., of New York. The tip is bent at an angle of nearly 90°, and is about one-fourth of an inch long. The opening is so small that the rubber bulb fills with air in about half a second after removal of the pressure of the fingers.



bodies. Nasal breathing was obstructed on the right side more than on the left. He had been treated by the galvano-cautery, by sprays, and by removal of pieces from the nose, with only partial and temporary relief. He was under the care of one physician for fifteen years. The sole treatment I employed consisted in syringing sweet oil down the nasal duct three times a week. At the end of four months the patient stated that his nose felt freer than ever before. He could breathe as well through the right side of the nose as through the left, and there was no discharge of mucus. The patient did not take cold as he formerly always did.

On October 15, 1893, more than a year after stopping treatment, the patient states that the relief has continued. He seems cured.

CASE II.—Mr. M., forty years of age, began treatment March 14, 1892. He had been a great sufferer from chronic naso-pharyngeal catarrh as long as he

To fill the syringe with water requires about five seconds, and to fill the syringe with oil may require several minutes. The tip is small enough to enter the smallest punctum, and tapers so abruptly that it closes the largest punctum, thus preventing a return flow of fluid. The syringe with its rubber bulb is about three inches long. A glass syringe is much lighter and cheaper than one of metal. Besides, with the glass syringe one can tell whether the injection is effective by observing the column of liquid. A syringe made with a glass barrel and metallic tip proved heavy and otherwise objectionable.

Care of the syringe is important. The point breaks very easily. A box should be prepared with a bed of soft cloth. The syringe should be placed in the box lengthwise and covered with a thick layer of cloth. Cotton gets into the opening of the

syringe and stops it up, but may be washed out with water. After using the syringe it should be returned to its case to prevent breakage.

Of the remedies used, olive-oil gave the most general satisfaction. Nitrate of silver was used in aqueous solution, from gr. v to gr. xx to 3j. A saturated solution was used in several cases without injury. Menthol 3j, olive-oil 3j, proved beneficial in some of the cases. This combination required extra care to keep the fumes out of the eye. Weak solutions of iodine seemed to act well in some of the cases. They seemed, however, to irritate after being used a number of times. Salt and water were used with temporary benefit in some cases. Solutions of alum, copper, and zinc were used without much benefit. Solutions of mercuric chlorid were not beneficial, and diluted camphorated oil was used without much relief.

To make the injection the operator sits in front of the patient. Artificial light from an Argand burner is reflected by the forehead-mirror on the inner side of the eye, direct illumination being less satisfactory. The operator may also stand behind the patient, who is then directed to look upward and outward. A piece of cotton about one-fourth of an inch in diameter is placed over the semilunar fold and held with the forefinger of the left hand with slight pressure against the upper punctum; this prevents the fluid from entering the eye from the punctum of the upper lid. The thumb of the left hand everts the lower lid sufficiently to expose the punctum. The syringe, partly filled with the fluid to be injected, is lightly held by the bulb with the thumb and first two fingers of the right hand, the tip is inserted into the punctum and the syringe turned until the tip is at a right angle to the margin of the lid and parallel to the conjunctival surface of the lower lid. Slight pressure is made on the bulb, and the level of the fluid in the syringe is seen to descend as the injection is being made. When the injection is finished, and as the syringe is removed, press the cotton with the left forefinger against the lower punctum to absorb any overflow of the fluid. The injection can be made with the eye closed. Some cases do not require the upper punctum to be closed.

Among the difficulties noted are the fact that the punctum may be so small that the tip of the syringe does not enter readily. Dilatation with a pin remedies this. It is seldom necessary to enlarge the punctum with a knife. Sometimes the injection is difficult after the tip is introduced into the punctum, and manipulation of the syringe up, down, and in various directions will be required to free the point from the obstructing conjunctival fold. Nervous patients give trouble, and in such cocaine helps, but does not always relieve, the difficulty.

More than five thousand injections of sweet oil were made without injury to the patients. Injections of other solutions at times seemed injurious. The glass syringe never broke or caused trouble during the injection.

The immediate effect of an injection of sweet oil down the nasal duct was to open the nasal passages. Many of the patients stated that the oil "opened the nose and head" more than anything previously used, and were concerned lest the air entering so freely the cavities of the head might be injurious. No case was so bad or had lasted so long a time but that the oil made the passages feel more free. The effect of the oil was to immediately lessen pain in the head, whether frontal, occipital, or temporal. In a case of spinal sclerosis with severe headache and shooting pains in the ears, the pain was completely relieved by syringing the tear-passages with sweet oil. The accumulation of mucus in cases of hypertrophic rhinitis is loosened at once, and can be removed by blowing the nose. In atrophic rhinitis no immediate benefit is noticed. The discharge is lessened in hypertrophic rhinitis, and may be entirely relieved. In atrophic rhinitis there is benefit, but the benefit is not so marked.

The beneficial results were not due to antisepsis. The oil did not act as an astringent; nor did it cleanse the nose. Its action must be explained through the nervous system. Ointments and oils relieve congestion of the skin and thickening of the skin; and oil in the nasal duct may by osmosis penetrate to the sinuses of the head, and, by its emollient or soothing effects on the nasal nerves, relieve congestion or hypertrophy of the mucous membrane.

64 EAST FIFTY-EIGHTH STREET.

THE MANAGEMENT OF THE EPICYSTIC FISTULA IN PROSTATIC ENLARGEMENT.¹

BY JOHN D. S. DAVIS, M.D.,
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EPICYSTIC surgical fistula is the title given to a suprapubic fistula into the bladder created by the surgeon for exploration, intra-vesical treatment, and drainage. Such a fistula, acting as an artificial urethra, is capable of giving free access to the interior of the bladder for cystoscopic exploration, to provide a ready, convenient, and comfortable means of emptying the bladder at will, and gives the surgeon a competent opening into the viscus for intra-vesical applications. It constitutes an essential element in the speedy and complete evacuation of the contents of the bladder in all epicystic operations, and imitates Nature in the restoration of its own

¹ Read before the Southern Surgical and Gynecological Association, November, 1893.

continuity as the pathologic changes within the bladder subside. Permanent after-drainage in all intra-vesical operations cannot be necessary, but it is highly essential to secure good and sufficient drainage until the paracystic tissue is disengorged, the cystitis relieved, the urine normal and passing by the urethra unobstructed. Until this end is attained complete artificial provision for the escape of the contents of the viscus must be made. In cases of prostatic hypertrophy or malignant growths, when removal of the obstruction is impossible or contraindicated, the epicystic surgical fistula is clearly indicated and essentially necessary.

When Dr. McGuire suggested his coffee-spout fistula for the relief of enlarged prostate, the idea struck me as unique and desirable; but before I had succeeded in establishing my first fistula after his method I found that practically it was not a success. In the first case in which I tried to create this kind of a fistula I found that I could not keep it in order. Finally, an abscess formed and opened on the pubic side, which allowed the urine to escape in a direct line, and I could never completely close the abscess-fistula or make the urine return to the original coffee-spout fistula. And, after many attempts at closure of the abscess or direct fistula, I finally made a plug or stem for the fistula resulting from the abscess, and allowed the original fistula to close. My experience with several cases operated upon with the view of creating a fistula after the method of Dr. McGuire convinced me that it was exceedingly difficult to create a coffee-spout fistula. I therefore began operating with the view of creating a direct fistula into the bladder, which I have heretofore described, by three methods:

1. When the distention is great and no intra-vesical operation is necessary, the opening is made with a trocar, withdrawing the stylet and replacing it with a rubber catheter, after the introduction of which the canula is withdrawn, leaving the catheter in the bladder. It is better to have the canula in place about twenty-four hours before introducing the catheter alone.

2. When distended the bladder may be opened by a direct incision with the knife in the median line, with the cutting edge toward the symphysis pubis. The knife is withdrawn and a catheter is introduced through the wound in the bladder.

3. A perpendicular incision, one or two inches long, is made in the median line above the symphysis pubis; the recti muscles are separated to the symphysis, and if the pyramidalis muscles are in the way the fibers should be cut. The transversalis fascia is divided on a grooved director from the symphysis to the upper margin of the superficial wound. I catch the bladder with a tenaculum, on a line with the symphysis, through the prevesical

fat, and with a bladder-knife I cut through into the bladder with one smooth clean incision, to prevent undue disturbance of the cellulo-adipose tissue between the bladder and the pubes and to avoid infiltration. Cutting this prevesical fat prevents it from dropping down afterward over the opening into the bladder and acting as a valve to prevent easy escape of urine, as also causing infiltration. Such a procedure also gives a smooth incision throughout, and it is almost impossible to have infiltration, even when no drainage-tube is left in the bladder, the urine being left to flow out through the fistulous tract and to be absorbed by a layer of cotton. In making the incision into the bladder little attention is to be given to any vein or veins that are sometimes met with. If cut they bleed but little. The operation is usually bloodless, so far as real hemorrhage is concerned.

The operation being completed and the patient out of bed, the annoying task follows. While suprapubic drainage is the best means that I know for treating those cases of prostatic enlargement, the fistula gives the patient a great deal of trouble. However well the fistula may drain, there will often be sufficient leakage to make the sufferer a pest to himself and to his friends. There is no possible way found as yet to keep the urine from occasionally leaking, and the fistula from occasionally inflaming. There is a constant tendency of the cutaneous orifice to contract and exfoliate that, if not carefully and properly treated, will cause a very unsightly wound and one that will be difficult to keep clean. As soon as the plug can be worn I have the patient wear it all the time—day and night. The plug I now use consists of a concavo-convex flange that coops over the mouth of the fistula and which, in some cases, aids in training the exfoliating tissues into a rudimentary penile projection that, when the patient urinates, will greatly aid in the prevention of dribbling. I show you a patient operated upon four years ago; he has no difficulty in keeping his abdomen dry, and is enabled to throw the urine several feet from his body. If he goes without the plug for a few hours his fistula so contracts that he can get the plug in again only with pain and difficulty. I had Tiemann & Co. make me a plug in two sizes of rubber, with a flat flange, which I use until the patient becomes accustomed to it. The concavo-convex flange sometimes so pinches the tissue when pressed down by the abdominal support that at first it cannot be worn. But after the cutaneous orifice has hardened for a while, the plug with the concavo-convex flange is better. The plug should be long enough to reach the bladder. But some few cases cannot tolerate the pressure of the plug in the viscus, and it should in these cases not quite reach the bladder-wall. I

have never seen two cases that could be treated exactly alike, and hence we have to be careful to adjust a plug to the comfort of each individual treated. When I first began to use the fistula-plug I had it made of silver and provided with a slight shoulder, one-fourth of an inch from the flange, to be grasped by the skin and held in position.

This shoulder, I thought, was a necessity in many cases to prevent the recti muscles from throwing the plug out. Experience has taught me that the shoulder is unnecessary and does not help matters. The best and most convenient way of keeping the plug in place is to wear an abdominal belt or support. The presence of the plug acts in preventing the artificial urethra from closing, and plays but little part in the power of retention and expulsion of the urine. There is a tendency of the entire track of the fistula to contract, but this is more pronounced at the cutaneous orifice. I do not think the recti muscles play much part in the retention of the urine, but there is formed at the vesical orifice a pseudo-sphincter that in many cases will so control the urine that the patient can retain it without dribbling for from four to six hours. I have never seen a case in which the wash did not have to be kept up daily. So long as the fistula is a necessity, there will be sufficient pathologic causes to necessitate the daily washing of the bladder. So long as the urethra remains incompetent, from whatever cause, there will remain sufficient vesical irritation to necessitate the daily washing of the bladder. In these cases, when the fistula is created with the view of permanency, there must be an admission that the patient has an incurable malady—prostatic, urethral, ureteral, or renal. While suprapubic drainage promises much in the way of temporary relief, the fistula cannot be long tolerated without a longing desire on the part of the patient to get rid of it. With these facts before us, are we not confronted with the necessity for further surgical aid for the relief of the causes that necessitate the presence of the fistula?

To be plain, in conclusion, after we have relieved the patient by drainage sufficiently to build him up strong enough to endure any kind of surgical procedure, ought we not to remove the prostate rather than continue the fistula?

Reinfection with Syphilis.—At a recent meeting of the Royal Society of Physicians of Vienna, NEUMANN (*Wiener medicin. Presse*, 1893, No. 49, p. 1943) presented a case of reinfection with syphilis, which had been under observation in the primary attack four years previously. The case was utilized to demonstrate the curability of syphilis, and, as the treatment consisted of ten inunctions and four injections of calomel, as an argument against the protracted method of treatment.

CLINICAL MEMORANDUM.

REPORT OF TWO CASES OF AMPUTATION AT THE HIP-JOINT, IN WHICH HEMORRHAGE WAS CONTROLLED BY TRANSFIXION-PINS AND ELASTIC COMPRESSION.¹

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THE renewed interest which has been manifested in the subject of amputation at the hip-joint, on account of new methods that have been recently introduced, leads me to think that the report of the following two cases may be of sufficient interest to engage the attention of the Society:

CASE I. *Amputation at the hip-joint for recurrent sarcoma after previous amputation at the middle of the femur.*—H. B., twenty-two years of age, a German-American, entered the Cincinnati Hospital, June 28th. His father, one brother, and a sister had died of pulmonary tuberculosis, his mother, two brothers, and a sister being still alive. He has had a chancre and buboes, but no general manifestations of syphilis. He drinks beer freely. He has been employed on an ice-wagon, and has had to lift heavy masses of ice, resting them upon his knee. On admission there was a swelling, involving the entire circumference of the lower end of the femur, just above the condyles, with some distention of the joint. This swelling was elastic, without any marked points of softening, and was free from bruit or pulsation. Great pain was complained of. The history he gave was as follows:

Last winter he began to suffer with cramps in his left knee, and a swelling soon appeared on the outer side, with greatly increased pain. The swelling continued to grow, and involved the entire circumference of the leg. The pain became continuous and so severe that half-grain doses of morphin, given hypodermatically, were necessary to give him even temporary relief. His temperature on admission was 100°, his pulse 90. Soon after admission an exploratory incision was made over the outer aspect of the limb by Dr. Evans, then on duty in my absence, and the condition found seemed to indicate the presence of a ruptured aneurism. The incision was closed and healed promptly. On July 7th the cicatrix opened at one point, and some bleeding occurred. On the following day the man was anesthetized, and I made an incision into the tumor in the line of the recent cicatrix, after the circulation had been controlled by a rubber tourniquet at the upper part of the thigh. The knife at once entered a large cavity, from which, under strong pressure, over a pint of fluid blood escaped. An incision four or five inches long, was now made on the inner side of the leg, and for some inches the femur was found bare and roughened round four-fifths of its circumference. This condition extended down to the intercondyloid notch. At the lower part new soft bone had formed from the periosteum. No tissue resembling tumor-growth was found, and there were no layers of fibrin such as are usual in aneurism. The incision on the inner

¹ Read before the Northwestern Ohio Medical Society, Toledo, December 15, 1893.

side of the thigh enabled us to explore the main vessels, and they were found intact. From the condition here found I considered that we had to deal with a periostitis, but as the bone was so extensively affected, I judged that amputation was the wiser course; and this was performed without removing the tourniquet. An examination of the part removed left it uncertain whether the disease was an inflammatory affection or sarcomatous. A subsequent microscopic examination by Dr. Evans proved the correctness of his view, expressed at the time, of the sarcomatous character of the trouble. The wound healed promptly, and the man immediately began to gain in flesh, and in a few weeks left the house, free from pain, and some pounds heavier than when he entered.

On October 6th, just three months after the operation, the man again came into the hospital. For several weeks he had suffered pain in the stump, which had been also growing larger. The skin over the end of the stump was reddened and distended, as from an underlying growth; there was no fluctuation, and the cicatrix was perfect. Great pain was complained of.

On October 8th, the man was anesthetized, the stump laid widely open, when a condition similar to that found in the first operation was discovered. The swelling was composed principally of fluid blood; there was, however, unmistakable evidence of sarcomatous growth about the end of the bone, and amputation at the hip-joint was, therefore, determined upon. It is to the method adopted that I desire especially to call your attention, as it differs in some details from the proceeding of other operators; combining the operation of F. Jordan with elastic compression of vessels in both anterior and posterior segments of the limb by means of transfixion-skewers and elastic tubing applied as a figure-of-eight over each half. Thorough disinfection of the entire limb, groin, and buttocks had previously been carried out in anticipation of disarticulation being necessary. The knife was made to enter midway between the crest of the ilium and the top of the trochanter, and, by a slightly curved incision, was carried over the outer aspect of the latter, and then down on the outer side of the femur to the face of the stump. This incision exposed the capsule of the joint, and the knife was carried down to the bone along the entire course of the incision. One or two small vessels spouted, and were at once secured by forceps. A long steel pin, prepared for the purpose, was at once thrust through the upper part of the wound, just in front of the neck of the femur, and made to come out on the inner side above the lesser trochanter. An elastic tube was then wound in a figure-of-eight over the anterior aspect of the limb, so as to include the ends of the pin, and thus securely occlude all of the vessels in the segment. The head of the femur was then rapidly disarticulated by cutting through the capsule, and freeing the muscles attached to the great trochanter. A second pin was now passed, coming out near the first, and the posterior segment was constricted in a manner similar to the first. The soft parts, from the stump upward, were now quickly peeled off the bone, which was thus easily enucleated. Before amputating the remaining mass of muscles, a third pin was thrust through the tissues from before backward just below the first two in place. This third pin was unnecessary and useless, and somewhat in the way. A circular incision was now made through the

skin, the femoral vessels isolated and secured, and the muscular mass cut through at a higher level. Absolutely no blood was lost. At points the muscles and intermuscular tissue presented a suspicious appearance, and these were carefully cut away with scissors. All visible vessels were secured and the pins then withdrawn. The loss of blood was practically none, and the operation was attended with little shock. The wound was closed throughout with the exception of a large-sized drainage-tube, which was carried into the acetabulum.

The progress of the case was satisfactory so far as the closure of the wound was concerned, but recently there have developed some symptoms that probably indicate recurrence of the trouble.

The method adopted in this case was suggested by the operation recently described by Senn, and is based on the same principle, namely, the control of hemorrhage by the independent constriction of the anterior and posterior segments of the limb above the point of amputation. Senn uses for this purpose simple pieces of tubing, without any skewer. After exposing the hip-joint by an incision similar to that of Langenbeck for excision, he disarticulates and then pushes a long pair of forceps through the tissue in front of the bone until it reaches the skin on the inner side of the thigh. The skin is incised and the forceps pushed through, and a strong piece of tubing, several feet long, is then grasped at its middle and drawn back and cut in two. The anterior segment of the limb is then constricted by tightly drawing the end of one piece across the face of the thigh, and tying or catching it by strong forceps. The posterior segment is then treated in a similar way. The entire circulation of the thigh is thus controlled by the two pieces of tubing. In a large muscular limb it would seem as though it might be difficult to secure sufficient compression of the vessels in this way, as the elasticity of a single thickness of the tubing is only available as a constricting force. The transfixion-pins, with the elastic tubing wound a number of times in a figure-of-eight over the limb must certainly secure firmer and more certain pressure, and the pins will be an additional security against slipping; and, moreover, they can be applied at a higher point, and by making the incision before the transfixion, they do not in any way interfere with the subsequent steps of the operation.

At the time of my operation I did not know that the plan I employed had been used before, but I find the account of an operation by Ogilvie Will,¹ in which the steps were identical, except that he had a single pin and applied constriction only to the anterior segment, as his flaps were cut somewhat differently. "The mode of operation I adopted," he says, "was that of F. Jordan, the skewer being passed from without inward between the bone and the soft parts in front of it through the upper end of the vertical incision, with which Mr. F. Jordan's operation commences." "The use of the skewer in hip-joint amputation originated with Spence, of Edinburgh." "The combination of Jordan's procedure with Professor Spence's skewers," he continues, "is most admirable, and really leaves nothing to be desired, for it is simple, easy, bloodless, and well adapted for drainage, while the presence of an un-

¹ British Medical Journal, November 16, 1889.

broken skin on the inner side of the thigh is a matter of no inconsiderable moment."

In Wyeth's method the closure of the vessels is secured by winding an elastic tube around the entire circumference of the limb, security against slipping being secured by two pins that pass the one within and the other without the bone. The encircling tube would seem to offer an embarrassment to disarticulation, if it did not prevent it entirely before removal. If I can judge from Wyeth's recent description of his operation, he effects disarticulation before removal of the tube, though he says it may be removed if necessary. In the *British Medical Journal*, January 4, 1890, R. J. Garden describes an amputation at the hip-joint in which he transfixes the limb from before backward, the skewer passing between the bone and the femoral vessels, the constriction of these vessels being secured by a rubber tubing carried over the skewer and the inner segment of the limb. A long inner flap was then formed by transfixion, cutting from within outward. There is no reason why this same plan could not be carried out after exposing the hip-joint by the anterior incision for excision, and subsequent introduction of the skewer after the capsule had been exposed and the joint examined. Indeed, this plan might possess great advantages in cases of tuberculous disease, when thorough examination of the joint was desirable before deciding on the necessity for amputation, or in cases of sarcomatous disease situated upon the outer and upper part of the femur. The preliminary exposure of the joint and upper part of the femur in the manner described facilitates the introduction of the skewer, which is then entirely out of the way of the manipulations necessary for disarticulation. One caution in using the skewer is necessary, namely, to see that it is strong enough not to bend under the traction of the elastic tubing.

I have recently performed a second amputation at the hip-joint by essentially the same method as that already described.

CASE II. The patient was a mulatto, twenty-two years of age, who some ten years ago had suffered an amputation at the middle of the leg for tuberculous disease of the ankle. Some months ago a new tuberculous process developed above and within the anterior superior spinous process of the ilium, which led within the pelvis. This had been several times scraped out. On November 27th his temperature rose to 102.5°, and continued high for some days, when an abscess burst on the inner side of the thigh and discharged a large quantity of tuberculous pus. No improvement followed this discharge, but the fever and septic symptoms continued. On December 6, he was anesthetized and carefully examined, full consent having been obtained for the performance of any operation deemed expedient. Close to the perineum on the inner aspect of the left thigh a large opening was found, where the abscess had spontaneously burst. The finger, introduced, passed up into the pelvis on the inner aspect of the tuberosity of the ischium, the depth of the cavity being so great that it could not be fully explored. The anterior opening, near the anterior spine, was traced downward, and bare rough bone found on the inner aspect of the ilium. A sinus from this opening passed down to the immediate vicinity of the anterior part of the neck of the

femur, but no connection with the joint could be found. The joint was exposed by the usual vertical incision on the outer aspect, reaching down well below the trochanter. This incision opened a large abscess outside of the joint, which did not seem directly involved. A rapid consultation determined that the removal of the limb gave the only possible chance in the presence of such extensive disease. A single pin was at hand, and this was passed anterior to the bone and brought out on the inner side of the thigh. The only tubing available was so light that the flat rubber Esmarch tourniquet was used for the purpose of the figure-of-eight constriction, and the traction was so strong that the pin bent considerably. On this account, as an extra precaution, an Esmarch bandage was wrapped a number of times around the limb below, and a circular incision was then made through all the soft parts, down to the bone. This was left intact in order to gain the advantage of leverage in the manipulation necessary for the disarticulation. The femoral vessels were now secured in the wound, and the Esmarch bandage removed. This latter bandage I am satisfied was superfluous, and I am confident that the light tubing would alone have given perfect occlusion of the vessels. The soft parts were readily separated from the femur from below upward, and disarticulation readily effected. A number of tuberculous foci were scraped or dissected out, the various sinuses packed with iodoform-gauze, and the wound closed. After several days the temperature fell to normal and the man showed marked improvement in every way. The results so far have been entirely satisfactory.

I have long been satisfied that amputation at the hip-joint should play a more frequent rôle in the operative treatment of tuberculous disease of the hip-joint than it does.

In this case the joint-cavity itself was not involved, but there was a carious condition of the neck of the femur that might soon have reached the cavity itself, and repair in the man's condition would have been impossible.

To enumerate the steps in the operation here described, we have:

1. The capsule of the joint is exposed by an incision on the outer aspect of the limb, similar to the one used for an excision.
2. A skewer is then passed through the upper part of this incision, in front of the bone, and made to present on the inner aspect of the limb. A piece of elastic tubing is now wound in a figure-of-eight manner over the surface of the limb and ends of the pin, securely compressing all the vessels in the anterior segment of the limb.
3. The head of the femur is now disarticulated by incising the capsule and cutting through the muscles inserted into the great trochanter.
4. A second skewer is passed through the limb, coming out at a point on the inner side near the first, and constriction of the posterior segment secured in the same manner as that of the anterior segment.
5. A circular incision of the skin is now made at the point selected, the muscles are cut through at as high a level as possible, and the vessels secured.
6. The femur is enucleated and the skewers removed

7. Closure of the wound is then effected, with such drainage as the case requires.

If for any reason it is desired to secure a long anterior flap, or if for any reason it is deemed advisable to approach the joint from the front, the incision may commence "below and within the anterior spine and run down between the tensor vaginæ and glutei externally and the sartorius internally, and expose the joint," as advocated by Marsh, and the skewer can then be inserted from before backward, between the femoral vessels and the bone, in the manner described by Miles.¹ The inner segment of the limb is then constricted by elastic tubing applied in a figure-of-eight manner. Amputation may be accomplished by transfixion or by cutting the flap from without inward, or by the circular method, if desired. Such a plan might at times be more desirable than the method by the incision on the outer side.

MEDICAL PROGRESS.

Some Neuroses Associated with the Menopause.—At a recent meeting of the Medical Society of London, SAVAGE (*Brit. Med. Journal*, No. 1714, p. 995) pointed out that many mental disorders occur at the menopause that cannot be traced to this as a simple cause, though in many cases it is a predisposing cause. No special form of insanity can be called climacteric, but as a rule there is a tendency to mental depression, rather than to excitement. Any of the symptoms of the menopause may be so exaggerated as to assume serious mental aspects. For instance, there may be a kind of climacteric hypochondriasis, manifested by complaints referred to the circulation, to the head, to the skin, or to the viscera. The unnatural feelings in the skin or about the body may lead to false accusations, and the development of hair on the face may lead to miserable feelings of being unnatural or unwomanly. Deafness sometimes arises at the time of the menopause and may lead to various delusions, particularly of a suspicious nature. There is a special form of insanity which is most frequent at the climacteric period, in which, with progressive deafness, there is a progressive development of delusions of suspicion, a form that is difficult of cure and which may be parallel to general paralysis of the insane, though affecting the sensory side and not so fatal as the disease affecting the more organic side of life. There is a great tendency to the development of disorders of the reproductive organs and of the feelings associated with their function. Thus, there is frequently jealousy, irritability, and general domestic incompatibility. There is also frequently hysterical disorder of one form or another; in single women there are false ideas as to marriage proposals and the like, and in married women a re-development of sexual desire that may lead to various forms of sexual excess. There is a great tendency to seek stimulants, morphin and similar drugs. The prognosis is fairly good in many cases, though in a large proportion, especially among those that have had other attacks of insanity, recovery does not ensue. Rarely the climacteric period is attended with a relief from existing mental or nervous affections. General

rather than special measures are indicated and the promiscuous use of the bromids is to be deprecated.

Symptoms of Syringomyelia from Syphilitic Tumors of the Spinal Cord.—At a recent meeting of the Clinical Society of London, BEEVOR (*Lancet*, No. 3664, p. 1252) reported the case of a married gardener, fifty-two years old, who two days after exposure to wet dragged the left leg. In the course of a few hours weakness appeared in the left arm, followed by wasting and numbness in the right knee. After the lapse of a week pain was complained of in the left shoulder, elbow, and wrist, with numbness in the left thumb and radial border of the forearm. In a short time weakness was observed in the left lower extremity and the numbness had extended to the groin and then to the level of the nipple. There was no affection of the sphincters, and no history of gonorrhea or syphilis could be elicited. On examination it was found that there was wasting of both upper extremities, especially of the left, with marked wasting and loss of power in the serratus magnus, supinator longus, muscles of the forearm, and intrinsic muscles of the left hand, as well as weakness of the left lower extremity; so that only the leg could be raised from the bed. Sensation was lost to pain, heat, and cold upon the whole of the right leg and the right half of the trunk up to the level of the fourth rib, while tactile perception was normal. The knee-jerk was excessive on the left side, and here ankle-clonus was present. Subsequently the loss of painful sensation extended up to the ulnar border of the right arm and to the radial border of the left forearm. There was loss of electric reaction in the intrinsic muscles of the hand. Later, paralysis of the sixth nerve of the right side appeared; the patient became gradually worse, and finally died. The case was believed to be one of syringomyelia. Potassic iodid was administered in small doses, without doing apparent good, but was not pushed, the treatment being tonic rather than anti-syphilitic. On post-mortem examination two syphilitic tumors were found on either side of the brachial enlargement of the cord, the left one passing nearer the cord than the right, but the condition of the cord precluded an accurate examination.

Fatal Intoxication with Benzene.—KELYNACK (*Medical Chronicle*, 1893, vol. xix, No. 2, p. 113) has reported the case of a woman, twenty-six years old, who, while under the influence of alcohol, swallowed about an ounce of benzene. Consciousness was lost; the pulse became quick and feeble; the respirations rapid and fairly deep; the pupils were contracted and irresponsive to light; the extremities cold, and the lips, ears, and nose distinctly blue. An intense odor of benzene emanated from the patient. The stomach was well washed out with warm water, the washings at first smelling strongly of benzene, and ether and strychnin were injected subcutaneously. In the course of three-quarters of an hour of such treatment the woman became sufficiently conscious to ask for some water. She then complained of great pain in the abdomen, and appeared also to be suffering from nausea and severe frontal headache. A little later diarrhea set in, and in spite of all stimulating treatment the pulse became progressively weaker and death took place from heart-failure twelve hours after

¹ British Medical Journal, November, 1889.

the ingestion of the poison. On post-mortem examination there was general congestion, and all of the organs and tissues emitted an odor not unlike that of anilin. The bronchi in several places presented small, irregular hemorrhages. The heart contained fluid and semi-fluid blood of a dark reddish-brown color. The stomach was small and contracted and contained only a little brownish fluid. At various parts of the jejunum the ridges of the valvulae conniventes presented hemorrhages. At about the middle of the ileum there was an irregular area about nine inches long, where the mucous membrane was of a dirty-gray appearance and surrounded by hemorrhagic edges. The urine in the bladder contained albumin, cellular elements, and hyaline tube-casts.

THERAPEUTIC NOTES.

The Therapeutic Uses of Organic Extracts.—ALTHAUS (*Lancet*, No. 3666, p. 1376) has reported some exceedingly interesting observations upon the therapeutic employment of glycerin extracts of the brain and spinal cord of healthy young animals, which he designates cerebrin alpha and myelin alpha respectively. Five minims were found to be a good initial dose for hypodermatic injection, preferably into the muscles, and given on alternate days or oftener. No essential difference was observed between the action of the two extracts. The length of treatment was variable. The results were, as a rule, encouraging. The physiologic effects in healthy persons consisted chiefly of feelings of increased nervous energy and buoyancy and greater capacity for physical and intellectual exertion without much subsequent fatigue. No appreciable change in temperature, pulse, respiration, and coarse muscular force was observed, although the appetite seemed increased and the action of the bowels more free. In some cases the amount of urea excreted was increased. The principal diseases in the treatment of which the extracts were employed were the chronic degenerations of the spinal cord, various forms of hemiplegia, paralysis agitans, and epilepsy. They were also used in a case of astasia-abasia, in one of grave hysteria, for the disabilities attending old age, and during convalescence from acute diseases. The general result arrived at was that neither extract is a specific for disease of the nervous system. In cases of epilepsy, paralysis agitans, and tremor, as well as in the usual forms of hemiplegia, they were found quite useless. On the other hand, the conviction is expressed that they constitute a nervine tonic of considerable efficacy in certain maladies and conditions mainly characterized by loss of nerve-power, and particularly as an adjuvant to other remedies. In conditions habitually looked upon as purely functional it is believed that good results may be obtained from the injections without any other active treatment, while in maladies in which the organic structure of tissues is damaged they seemed to act chiefly as adjuvants and intensifiers of other treatment. Of fourteen cases of neurasthenia six were successfully treated with injections alone; six others improved under combined treatment; and in two aggravated cases there was no change for the better. Of fourteen cases of posterior spinal sclerosis the condition was improved in ten. Of

four cases of spastic paralysis three greatly improved. In three cases of progressive muscular dystrophy in adults decided benefit ensued. In a few cases the treatment disagreed, constitutionally or locally. It is admitted that at the date of reporting sufficient time had not elapsed to permit an affirmation as to the permanency of the results obtained. The conclusion is expressed that the action of the extracts is twofold. In the first place they may be looked upon as a highly specialized pabulum of nervous matter by reason of the presence of protagon, cerebrin, and lecithin, as determined by chemist analysis; and in the second place they appear to act as antitoxins, as the phosphorized bodies split up under the influence of the alkalinity of the blood into glycero-phosphoric acid and cholin, which have the power of stimulating intra-cellular oxidation and the elimination of leukomains.

The Elimination through the Saliva of Morphin Subcutaneously Injected.—As the result of a special investigation, ROSENTHAL (*Berliner klinische Wochenschrift*, 1893, No. 49, p. 1189) has determined that when morphin is injected subcutaneously it is eliminated through the saliva in not inconsiderable quantities, even when the dose administered has been small and not in excess of minimum therapeutic amounts. Its presence is the more readily detected when the small doses have been given for several days consecutively. The period during which morphin is eliminated through the saliva cannot be determined by means of the methods heretofore in vogue of administering therapeutic doses to human beings; the relation of the quantity injected to the quantity eliminated can be only approximately determined. Morphin has a tendency to accumulate in the system, and is only gradually eliminated. A positive reaction of the gastric contents to tests for morphin and the qualitative determination do not afford conclusive and direct evidence of the presence and the amount of the alkaloid eliminated by the stomach, if the discharge of saliva into this viscus has not been excluded. In case of suspected poisoning with morphin examination of the saliva would be indicated.

Iodo-cafein, Iodo-thein, Iodo-theobromin represent combinations of caffein, thein, and theobromin respectively, with sodium iodid. Iodo-cafein is prepared by dissolving 35 parts of sodium iodid and 65 parts of caffein in water in the cold, treating the solution with hydrogen arsenid and evaporating to dryness. There result colorless crystals, soluble in water at a temperature of 95° in the proportion of 14.5 per cent. Iodo-thein is a white powder, soluble in the proportion of 18 per cent. The preparation of iodo-theobromin is attended with more difficulty, the addition of a concentrated solution of sodium salicylate to the mixture of sodium iodid and theobromin being required. All three are unstable chemically and undergo decomposition in hot water. All stimulate the action of the heart. Iodo-theobromin increases more than iodo-cafein the energy of the systole, arterial pressure and diuresis. Neither influences the respiration or the temperature, and both are well borne. They are rapidly eliminated by the urine. The dose for adults is from 5 to 20 grains, in wafer.—RUMMO, *Sem. Med.*, October, 1893; *Deutsche med. Wochenschr.*, No. 50.

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THE NOMENCLATURE OF CHEMIC TERMS.

THE extension of nomenclature in chemistry has been almost entirely in the organic department. In the inorganic field the terms are much the same as they were when their author's head rolled into the basket during the Reign of Terror. The useless "of," introduced originally through a too literal translation of French phrases, has been almost entirely eliminated, and the more satisfactory theories as to the structure of salts have brought about the substitution of such expressions as calcium carbonate and sodium nitrate for the older carbonate of lime and nitrate of soda.

In organic chemistry the resources of terminology have been highly taxed to secure a comprehensive nomenclature. In rapid succession, avenues have been opened up leading to luxuriant fields of discovery, and in many cases compounds have been obtained to which no systematic name can yet be given, and for which an arbitrary or fanciful title must, for the time being, suffice. Organic compounds being in great part composed of the same elements, no system based merely on indicating these elements can be applied. This simple method is practicable in the mineral chemistry. In the nomenclature of organic bodies the aim is to indicate structure and structural relationships; names

based on any other system are temporary or accidental. Marked advance was made in April, 1892, by an international convention which met at Geneva to revise the nomenclature of chemic terms. It is regrettable that the new Pharmacopeia did not observe the salient points of the decisions of this convention, for there is little doubt that long before the next revision is made chemists and pharmacists will have accepted the system. This nomenclature is, of course, distinct from the question of reformed spelling, although the committee of revision appears not only to have confused the two issues somewhat, but also to be inconsistent with itself. Thus, in the preface, the committee states that it was considered inadvisable to drop the final "e" in "chloride," "bromide," etc., yet in the body of the work the "e" is dropped in "acetanilid," which is as much an innovation in spelling as "iodid." The terms "glycerol and benzene" are referred to as if they were novel or unusual, whereas they are in extended use in both America and England, and no chemist who is careful as to his phraseology now uses benzol as the name for the benzene. In fact, benzol is now a name, in the coal-tar trade, for a product containing several ingredients. It is also a matter of regret that the absurd spelling "naphtalin" is used for "naphthalene;" nor is it clear why a recent reform in German spelling has been allowed sufficient influence to make "naphtol" out of "naphthol." The disadvantage of the termination "ine," which the committee thinks useful as indicating basic properties, is shown in the case of caffeine, the title of which to the final "e," which the Pharmacopeia gives it, is doubtful. A further eccentricity in nomenclature is shown in the rule of forming the Latin names of the salts with a genitive construction, while the English equivalent is put in the nominative. Thus, *potassii chloras* is the equivalent of potassium chlorate. The retention of the term hydrate, when almost all chemists have adopted the term hydroxid, which is so much more in accordance with our modern notions of structure, is also unfortunate.

The United States Pharmacopeia is not a textbook of chemistry; it is not even addressed to the teachers and workers in chemistry outside of medicine, nor has it any authority with them. In its chemic terms, therefore, it should defer to, not resist, the tendency of pure chemistry. The nomenclature which has received the approval of the American Association for the Advancement of Science, of the Association of Official Agricultural

Chemists, of the American Chemical Society, of the Chemical Society of England, and of such journals as the *Chemical News*, should not be dismissed as awaiting acceptance. As the committee adopts without hesitation the rules for botanic nomenclature promulgated by the Botanical Club of the American Association for the Advancement of Science, why should not the Chemical Section of the same Association be given equal weight?

A judicious approval of the generally accepted points of nomenclature in chemistry would have done much toward securing the adoption of the exact phraseology by physicians, who stand sorely in need of correction in this respect.

The following summary includes the more important points in the nomenclature of organic chemistry as now generally accepted:

-ol indicates alcoholic structure, *i. e.*, presence of the group HO (hydroxyl), *e. g.*, alcohol, glycerol, phenol.

-ose indicates a carbohydrate, *e. g.*, glucose, although it is also occasionally applied to the results of digestion of proteids, *e. g.*, albumose.

-ase indicates an enzyme, or non-organized ferment, *e. g.*, diastase. This termination is at present restricted generally to enzymes of vegetable origin, but it should also be used with animal enzymes—which, however, usually end in “in.” It would thus be better to say *pepsase* and *trypase*, rather than *pepsin* and *trypsin*.

-ane indicates a saturated hydrocarbon.

-yl, *-ene*, *-enyl*, and *-ine*, indicate hydrocarbons.

According to the American system of orthography the only case in which “*ine*” is used, is as a termination for certain hydrocarbons. The preceding vowel is long.

-al indicates aldehydic structure.

-in is of no precise significance, and is mostly applied to bodies the structure of which is not yet known.

-id is similar to “in.”

As to prefixes:

Ket- indicates the molecule CO in certain structural relations.

Azo-, *diazo-*, and *hydrazo-* indicate compounds in which nitrogen atoms are linked in various ways.

Nitro- indicates the group NO₂.

Am- indicates the group NH₂.

Im- indicates the group NH.

Thio- indicates sulfur, especially replacing oxygen.

The word *sulfonic* indicates the group HSO₃.

Except as noted, the termination *-ine* is not now used by American chemists. English writers, however, use it to signify basic properties, regarding *-in* as the proper term for non-basic bodies. They thus distinguish between salicin, which forms no salts with acid, and morphin, which does. It must be noted, however, that such methods are not in accordance with the tendency of nomenclature which seeks to express structure, not properties. The organic bases or alkaloids are not all of the same type, and when their structure is elucidated systematic names will be found for them. Until then there is no particular gain in indicating them as a group.

THE PHYSICIAN AS A SOCIOLOGIC FACTOR.

WE hold that it is directly within the physician's sphere of action to interest himself in all such movements as tend to prevent disease and improve the health of the community in general. Whilst it is undoubtedly the principal function of the physician to cure particular cases of disease, a large conception of his duty makes it plain that he should also act as a preventer of diseases in general. Such, indeed, is the tradition of the profession.

We are aware of the fact that the “city doctor” who has attained to any degree of eminence is usually a very busy man. With the ordinary duties pertaining to his private practice he combines those of teacher, author, investigator, and hospital official, to say nothing of what is demanded of him by the various scientific bodies which are honored by his fellowship. It would be extremely inconsiderate to ask such a one to devote any considerable portion of his time to the interests of the community or to the public in general. As a scientific investigator he may discover truths of the greatest importance to the whole world, and hence one may become a public benefactor who has never been seen or heard outside of his laboratory.

There are, however, many young members of the profession who, unfortunately for themselves, are not in possession of a lucrative practice, who are not particularly trained or expert in scientific research, and whose experience is yet too limited to permit them to become authors or teachers. They are, indeed, practically wasting much valuable time and ability. These “patient-waiters” if we so dare to term them, are found in the country towns, as well

as in the city, and we believe they can be of immense service to any community and likewise benefit the science of medicine and themselves by taking a more active part in those social questions of the day that have relation to preventive medicine.

It has been said that "No other profession is doing so much toward ending its own existence as the profession of medicine." This is true, even if we consider ourselves merely as therapists, or curers; but it is especially true of every effort in the line of prevention of disease, because that must limit the scope of our action as to its treatment. But if, as healers of disease, we are making ourselves less necessary with each new discovery, can we not make ourselves more useful as custodians and preservers of health.

For example: We all know how clearly preventable is that host of diseases arising from want of cleanliness. There is a dangerous ignorance on this subject among the people generally. Cannot the young physician do something to educate the masses in the matter of hygiene? It is not wise to overcome ignorance by force or expect a faithful adherence to sanitary principles if the necessity for such laws is not understood by the people themselves or by those who administer the laws.

Movements that relate to the better housing of the poor, to prevent overcrowding, that seek to establish breathing-spaces in the crowded parts of cities; efforts to secure better streets, pure water, less noise, less imperfect drainage and better disposal of garbage—all these are truly health-questions, and deserve the active coöperation of the young physicians, and the older ones too, for that matter.

The reform of municipal government is not entirely foreign to medicine, as without good government sanitary measures are not likely to be properly executed, and, therefore, both as a citizen and as a physician every member of our profession ought to be interested in municipal reform, and the younger members especially should do their part in its advocacy. Crime, pauperism and inebriety are called social diseases, yet they are closely dependent for their causation on physical disease, and on the other hand many physical diseases owe their existence to these social evils. Some go so far as to call all crime and inebriety disease, physical disease; others consider them the outcome of social conditions. It is the old question of inheritance, predisposition, and contagion, so often discussed in medical litera-

ture, carried into the morals of the world. Whatever the answer may be, the dependent and delinquent classes are more and more, in one way or another, coming under the care of medical men; they are being looked upon as abnormal and pathologic, rather than immoral and depraved.

All studies, therefore, of the causes of social diseases are not without the domain of medicine; and a knowledge of the social conditions of the masses, gained from actual observation, must be of value in such studies. In the smaller towns education of the old and young in health-matters, school-hygiene, etc., is as necessary as in the larger cities. Epidemics of contagious disease often create great havoc in the village communities from lack of centralized power to prevent the spread or discover the cause.

Many towns have already organized boards of health consisting of medical men. Every community, no matter how small, should have such a department, and it is for the younger men to form and control such an organization, and to guard it jealously from political debauchery. We know that no such encouragement is extended to the young physician who wishes to carry the "gospel of health" to the heathen in the city slums as he receives who, as medical missionary, declares his intention of seeking to convert the far-away African or Hindoo. But as a profession we are self-sacrificing enough to do our duty whether we see a return for it or not.

We believe that the physician can play a more important part than heretofore in public affairs; that it is not beneath his dignity nor without his province to do so; that the younger members of the profession can make themselves especially useful as educators, and that the science of medicine itself can be benefited in consequence.

EDITORIAL COMMENTS.

Authority of Boards of Health to Suppress Nuisances.—In a matter so serious as that of the public health, the Court of Appeals holds, in the recently decided case of *Board of Health v. Copcutt*, that a board of health ought not to wait until some citizen is sick or dead before it prevents or abates the nuisance causing the injurious result. Thus, when a statute is provided specially for the removal of a nuisance, the people are not compelled to await its completion, but are awarded an injunction to restrain the further erection, and compel the removal so far as erected. So a board of health has power to prevent a reconstruction and a reinstatement of what it has declared to be, and what the court has found in fact was, a public nuisance. In this particular case,

which was an action brought by a board of health to enjoin the maintenance of a dam, the owner contended that when he built the dam the stream was clean, and the water pure; that he never did anything to pollute it, or to make it injurious to health; that it came into that condition from the acts of others; and that his property was destroyed, and he was forbidden to restore it, without any fault of his own. The court answered to this that the dam and pond were his. He had a right, it was his duty, to keep them clean and safe, or dispense with them entirely if he could not. His dam was a pocket to catch and hold all filth thrown in above. He well knew it, and could not sit still and suffer his own property to become an intolerable nuisance, and say it was not his fault. When pestilence is forcing its way into our harbors, and danger and death approach through all rot and filth, it is the condition with which boards of health must grapple, and the condition which must be abated or removed, without regard to the question who caused the trouble. However innocent the owner of the property may be in creating the condition or maintaining it, he is bound to abate it upon the proper official request, and, if he refuses, he becomes at once responsible for the existing condition, as continuing a nuisance which it was his right and duty to remove and suppress.

The Editor Blesses the Advertisers.—We feel sure that one of our active Western contemporaries (who, by the way, has been making a most commendable fight for medical-practice reform in his State) would feel sorely aggrieved if any but himself had suggested the possibility implied in the following quotation taken from a recent number of his not unimportant journal: "Not infrequently as much or more valuable information may be found in the advertising than in the pages devoted to what is known as pure reading matter." Unconsciously, perhaps, with the thought of removing the force of this imputation he endeavors to restore a condition of equality by introducing into his editorial columns commendatory notices of a number of his (pecuniarily) most important advertising patrons. To augment this missionary work we would suggest that our ingenuous contemporary might make up his entire journal with advertising matter. There would then be no odious comparisons or invidious distinctions to make, and he might feel sure that the profession were being well educated, according to the standard that he seems to have established.

Original Articles in The Medical News.—The *Journal of the American Medical Association* publishes the results of a statistical inquiry as to the original articles that have appeared in the principal weekly medical journals of the United States during the past year. We are gratified to learn that THE MEDICAL NEWS in the last volume devoted a larger number of pages to original articles than any of its competitors, the *Journal of the Association* of course excepted. We doubt not if the distinguished editor of the *Journal* had been permitted to have his way—that is, if he had been allowed to use his excellent editorial discrimination—the number of his pages of original articles would have been much less. We reproduce the figures in by no means a boast-

ful spirit, but we confess our pleasure in finding that other periodicals with a higher subscription price, and claiming a greater number of total pages, do not in the year give as many pages of original articles as THE NEWS. This just pride is increased when we recall the fact that every contributor to the columns of THE NEWS has received due compensation, a feature which we believe to be peculiar to THE NEWS. "The laborer is worthy of his hire." We append the *Journal's* figures:

July 1 to December 30, 1893.	Journal American Medical Association.	New York Medical Record.	New York Medical Journal.	Boston Medical Journal.	MEDICAL NEWS.
Number of original articles . .	240	176	158	132	175
Number pages original articles	665	334	380	300	397
Total number pages	1024	860	816	660	756

The Exciting Cause of an Injury Viewed Legally.—

According to a decision of the Supreme Court of Wisconsin, in the case of *Vosburg vs. Putney*, medical experts can testify to the exciting cause of an injury. In this case action was brought to recover for an injury caused by one boy kicking another, a little below his knee, while in school. The defence made was that if disease existed in the boy's leg before the injury complained of was inflicted, and such injury merely served to accelerate its progress or to locate the point of suppuration, and was not the original cause thereof, or if the proximate cause of the inflammation in the leg was the presence of pus-germs which obtained entrance by way of a previous wound above the knee, no recovery could be had. But the court refused to so instruct the jury. The law on this point was held to be that if the kick inflicted was the exciting cause of the injury complained of, and such injury was the natural consequence of the kick, the one inflicting it was liable therefor, although the physical condition of the person kicked might have aggravated the injury. The jury in this case assessed the damages at \$1200.

The Use of Patent Medicines as Evidence of Legal Want of Care.—

A so-called patent medicine may or may not be a curative agent, and there must be some evidence upon this point before an issue of fact is raised. So holds the Court of Civil Appeals of Texas, in the recently decided case of *Gulf C. & S. F. Railway Co. vs. Brown*, which was an action brought by the latter to recover damages from the railway company for a personal injury, and in which one of the defences pleaded, besides a general denial, was that the man had not secured proper treatment, or taken proper care of himself, thereby aggravating his injuries, and also having resorted to the use of patent medicines. The fact that he had used, and applied to his hurts, a patent medicine, the court continued, was not evidence of the want of care in treating his injuries. It seems strange that a railroad or any other product of civilization could have penetrated so far as the dense barbarism of that judge's district.

Comparison of City Death-rates.—Our esteemed contemporary the *Philadelphia Press* takes exception to the views advanced recently by THE NEWS concerning the percentage of deaths in some large cities. The *Press* argues that the higher death-rate of New York over London may be accounted for to a considerable extent by the greater extremes of temperature, and by the overcrowding in the tenement districts. Extremes of temperature are certainly as great in Chicago as in Philadelphia, and comparison of the numbers of deaths from diseases of the respiratory tract does not bear out the contention of our excellent contemporary. It must also be noted that it is not likely that New York is more overcrowded than some districts of London and Berlin, and further analysis of the mortality statistics shows that the tenement district in New York is not distinguished by a specially high death-rate. Infant mortality, as the *Press* notes, is high in American cities during the midsummer, but a large proportion of such deaths are due to preventable diseases. When we turn to the typhoid statistics we see the difference in the sanitary state very clearly. London has a typhoid death-rate of 0.49 per thousand per year, Berlin slightly less, 0.42; while New York's death-rate from this disease is more than double that of Berlin, that of Philadelphia over five times, and that of Chicago still more.

If the population of Philadelphia equalled that of London, with no alteration of its sanitary conditions at present existing, there would be in Philadelphia twenty-seven hundred deaths annually from typhoid fever against four hundred and twenty-five in London. The *Press* also argues that the somewhat lower death-rate (from all diseases) in Chicago than in New York or Philadelphia is due to the greater number of young adults in the Western city. But would not the same argument apply to our Eastern cities in comparison with London and Berlin? The proportion of young adults must be rather larger in American than in European cities. If this is the case the death-rate is still more disproportionate than the figures at first sight indicate. It is undoubtedly true that natural and irremediable conditions operate in some cities to render the mortality higher; but it is also true that an analytic study of the mortality lists shows that a large element of fatality is contributed by diseases the causes and means of prevention of which are known and practicable to municipal administrations.

It strikes us that it would be more needed advice to our citizens to warn them of such things as the dangers of drinking the sewage of several hundred thousand people rather than to blunt the edge of needed criticism by labored arguments in the old art of *laissez-faire*.

Enterprise, Journalistic and Professional, is displayed by the custom quite common nowadays in certain parts of the country, for the local daily newspaper to publish a special edition largely devoted to biographic and eulogistic notices of "Successful Doctors." The details of the successful careers are blazoned with liberal colors, the office hours, specialties, telephone-numbers, etc., following in each case. The fellow who pays the most, and furnishes the most glowing and particularized accounts of himself, and who orders the greatest number of hundreds of extra and marked copies for distribution to his

clientèle, is, of course, he that "takes the cake." It is mortifying to find certain names in these lists of dishonor.

Non-expert Testimony as to Blood-stains.—Persons not experts are allowed, in proper cases, to testify as to what they have seen, when, perhaps, expert testimony would be more conclusive. Thus the Supreme Court of Missouri holds, in the recently decided case of *State v. Robinson*, that a non-expert can testify that the stains which he observed on a certain garment "looked like" blood-stains. This court also says, in the same connection, that frequently the *opinion* of a witness as to the appearance of an object he has seen is the best and only evidence obtainable; nevertheless it is competent.

The Physicians of Ohio have been holding a convention at Columbus, and have formulated a medical-practice bill for presentation to the Legislature. It is thought that at last some sort of control of the medical abuses of the iniquitous conditions prevailing may at last be reached. Any five men, simply upon application to the Secretary of State, can secure a charter for a college and grant diplomas for any or for no consideration whatsoever.

The Way to Stop the Reading-notice Evil.—An eminent professor in one of our universities writes us that, after vainly protesting to the editor of one of our foremost medical journals against concealed advertisements in the reading columns, he has ordered the journal to be sent to him no longer.

SOCIETY PROCEEDINGS.

NEW YORK NEUROLOGICAL SOCIETY.

Stated Meeting, held at the New York Academy of Medicine, Tuesday Evening, January 2, 1894.

DR. M. ALLEN STARR, PRESIDENT, IN THE CHAIR.

DR. J. LEONARD CORNING narrated the case of a young man, eighteen years old, who had received a severe kick directly over the right ear while engaged in a game of foot-ball. He was first seen by Dr. David Webster, who, upon careful examination, found that there was total deafness on the right side; aerial conduction and bone-conduction were suspended. There was no trouble in the middle ear, and the drum was in perfect condition. There was slight bleeding from the external ear, but no evidence of fracture. A rapidly interrupted faradic current was applied to the ear and allowed to pass for about ten minutes, when the hearing was so far restored that the patient could hear a watch at a distance of six inches. Before making the application, the external meatus was plugged with absorbent cotton moistened in salt-solution. A severe tinnitus that had coexisted with the deafness was also relieved. Dr. Corning said that he had no idea what the lesion was, or why improvement followed the use of the current; it was employed simply as an empiric measure. The young man's hearing is now entirely restored. There was no suspicion of hysteria. The visual field was not tested.

DR. DAVID WEBSTER said that he supposed the deafness was due to concussion either of the auditory nerve or of the labyrinth, of which he has seen cases reported.

Temporary blindness has been produced by a sudden blow on the brow, without ophthalmoscopic or other lesion. Most of those cases, however, are due to fracture of the base of the skull, involving the optic foramen and producing nerve-atrophy. He has never seen a case similar to the one reported.

DR. STARR suggested that the case might have been one of traumatic hysteria or concussion of the auditory nerve. In consultation with Dr. Jacobi he recently saw a case of total deafness of central origin, in which temporary improvement in the hearing was produced by the use of a strong galvanic current—about six milliamperes, which is a strong current for the acoustic nerve.

DR. J. ARTHUR BOOTH said that in a number of cases of tinnitus he has employed the galvanic current with marked benefit. He also never saw a case similar to the one reported.

DR. RALPH L. PARSONS read a paper entitled "Report of a Case of Akromegaly." The patient was a man, thirty-six years old, with a negative family history. He had never had venereal disease and had not used alcoholic stimulants. He was in good health until eighteen years ago, when he had an attack of malarial fever. From this he recovered and has had no recurrence since. Ten years ago he was told that he stooped and carried his head to one side. Two years later he began to suffer with pain in the back of the head. This came on mostly at night, and not oftener than once a week. Subsequently the headaches occurred more frequently by day than by night. Latterly they have increased in frequency and duration and have often been excruciating in degree. The pain was usually most severe at the occiput, but would also involve the left parietal and frontal regions; the right side of the head was unaffected. About six years ago his attention was first called to the large size of his hands. He then for the first time perceived that they were of extraordinary size. He does not know for how long a time this increase in size has been taking place. He cannot say whether or not the hands have increased in size during the past six years.

In October last the patient weighed 227 pounds. He presented no pronounced symptoms of organic disease. His hair was rather coarse, but natural in condition. The left ear was slightly thickened. The forehead was retreating; the superciliary ridges quite prominent. There was no exophthalmos. The malar bones were rather prominent; the cheeks appeared sunken; the nose was broad and full at the nostrils; the lips were normal. The tongue was decidedly enlarged, obstructing free articulation; the alveolar processes normal; the teeth not separated; the chin was elongated. The head was inclined strongly and habitually to the left side and forward. The hands were large and spade-like, the right hand being decidedly the larger. The soft tissues of the hands and fingers were firm and resilient, as though infiltrated by an elastic substance; they did not pit on pressure. The wrists were rather large; the arms normal; the thorax and pelvis normal. The feet were large, but perhaps not more so than in the case of many men of the same weight. The patient has perspired very freely for the past ten years; but of late the perspiration has been decidedly offensive. Besides the headache referred to, the patient also complained of pain

in the left ear and eye, the latter coming on after reading or using the eye in a strong light. He does not think that his eyesight has become impaired. Appetite and thirst are excessive. There are no marked mental symptoms.

On the 21st of October, by advice of Dr. Starr, the patient began the use of a thyroid extract, five drops three times daily. The dose was gradually increased until the man received fifteen drops three times daily. With the exception of tonic baths, general hygienic measures, and a regulation of the diet, no other treatment was given. At the present time the patient reports that he is feeling decidedly better. He is more cheerful, and his headache has been relieved to a great extent. It has not, however, entirely disappeared. There seems to be no change in the dimensions of the hands. The weight has increased rather than diminished. There has been a great improvement in the subjective condition, but there is still a reasonable doubt whether this improvement is due to the direct action of the medicine or to the patient's mental status induced by the fact that something is being done for his relief.

DR. STARR said that the use of thyroid extract in the case narrated is purely empiric. The supposed lesion of akromegaly is an increase in the size of the pituitary body. It is questionable whether it is in any way related to the thyroid gland. The eye-symptoms in the case narrated are interesting, because in two other cases of akromegaly coming under observation there was a concentric diminution of the visual field, and in one hemianopsia; the latter symptom is quite common, and is probably due to pressure on the chiasm by the enlarged pituitary body. In one case of akromegaly seen at St. Luke's Hospital death resulted from pneumonia, and at the autopsy the pituitary body was found to be normal. There was nothing to account for the peculiar growth of the bones.

DR. PARSONS said that it is generally supposed that there is a sort of relationship between akromegaly and myxedema; whether this belief is well founded or what that relationship is is not known.

DR. J. LEONARD CORNING read a paper entitled "Some Less-Cultivated Phases of Psychology; Considerations on the Genesis of the Feelings, or the Relation of Desire to the Will-function; Practical Deductions therefrom concerning the Management of Various Psychopathic Conditions." He traced the relationship of the desires to the function of the will, and showed the importance of psychic influences in the correction of certain morbid mental conditions. In neurasthenia, simple melancholia, hysteria, and other functional nervous troubles the desires are best evoked and fostered through the special senses, notably through the sight and hearing, while at the same time the receptivity of the sensorium is increased by proper stimulation. The effect thus gained is not necessarily evanescent. Due heed should also be given to the general bodily condition. Nutrition must be improved and gouty and other morbid tendencies antagonized. The question of influencing the mind to the advantage of the patient is certainly an important problem in neurology, and one well worthy of discussion. In concluding the paper reference was made to the loss of prestige that has apparently overtaken hypnotism, which in too many instances only

served to substitute a veritable neurosis for the morbid condition that it was sought to modify.

DR. W. H. THOMSON said that his own plan in the treatment of melancholia has been not to appeal to the will of the patients at all; it is only discouraging to them to tell them to think less of their condition; their train of thought should be involuntarily changed by new objects brought to their senses, either through the eye or the ear. By means of a change, using the word in its broadest sense, a change of scene, of surroundings, and of society, the endeavor should be made to produce an involuntary displacement of the morbid ideas.

DR. WILLIAM H. THOMSON read a paper entitled "Ergot in the Treatment of Periodic Neuralgias. He gave the histories of a number of cases of severe periodic neuralgias in which the symptoms were promptly relieved by the use of ergot in large doses. In all of these cases the disease was of long standing, and the usual remedies had been employed without avail. The method of administering ergot in migraine is as follows: The fluid extract of the drug is employed, combined with an equal quantity of elixir of cinchona, to overcome the tendency to cause nausea. Two drams of this mixture are to be taken in water as soon as the premonitory symptoms of the headache are noticed, and the patient is advised to lie down and keep very quiet. If, after an hour, the headache continues, a second similar dose is taken, and then a third in another hour, if necessary. As nausea is such a general accompaniment of migraine, it is provided that if either of the doses be vomited, the medicine should then be taken in an enema of two ounces of water. This medication, it was said, rarely fails to arrest the attacks, even in cases of long standing, and with a preventive course of intestinal antiseptics in the intervals, the relief from the malady has often proved permanent.

DR. JOSEPH COLLINS said that he had recently employed ergot in the treatment of several cases of periodic neuralgia. In one case, in which huge doses of Warburg's tincture, quinin, potassium bromid and iodid had been given without benefit, dram-doses of ergot were followed by a marvellous improvement. In another case, in a lady, forty years old, who had long been under treatment for migraine, the therapeutic value of ergot was discovered accidentally; it was given to check a menorrhagia and it at the same time relieved the headache.

DR. C. A. HERTER said that in the treatment of cases of migraine he lays greater stress upon the diet and nutrition than he does upon drugs. He employs very few drugs, chiefly aconitin. He is decidedly opposed to the use of the antipyretics.

DR. CORNING said it is important to determine whether the pain is extra-cranial or intra-cranial. He referred to the value of compressed air in relieving intra-cranial pain. External pains, on the other hand, are aggravated by the compressed-air treatment.

DR. THOMSON referred to the fact that quinin, even in small doses, when combined with ergot, appears to produce cinchonism much more quickly than when given alone. In only one of the cases reported was there any antecedent history of malarial infection, and in that case the patient simply had resided in a malarious district. Very likely there was a malarious element in the other

cases, of which the nervous symptoms were the only manifestations. Dr. Thomson also referred to the fact that intercostal neuralgia is often accompanied by sciatica; also the occurrence of sciatica after pleurisy. The latter combination he has noticed in about twenty cases.

NEWS ITEMS.

The Medical Society of the State of New York will hold its eighty-eighth annual meeting February 6th, 7th, and 8th, in the City Hall, at Albany. The following provisional scientific program has been arranged:

Hemorrhagic Serous Effusion into the Pleura, with Report of a Unique Case; by William S. Cheesman, Auburn. Researches on the Eliminating Power of Diseases, and the Relation between Vaccina and Enteric Fever; by William Finder, Troy. Pneumonia of the Aged; by John H. Pryor, Buffalo. Diagnosis and Nomenclature of Fevers—second paper; by Nelson G. Richmond, Fredonia. The Therapeutics of Oxygen; by Arnold W. Catlin, Brooklyn. Simple Methods in the Diagnosis of Nervous Diseases; by E. C. Spitzka, New York.

Discussion on Diphtheria.—Pathology—Status Præsens; by Thomas E. Satterthwaite, New York. Observations on Diagnosis, and some Sanitary Aspects; by A. Walter Suiter, Herkimer. Croup and Diphtheria—Unity or Duality; by William H. Daly, Pittsburg, Pa. The Comparative Status of Intubation of the Larynx; by Joseph O'Dwyer, New York. Complicated Intubation of the Larynx; by William Hailes, Albany. The Local Treatment; by Abraham Jacobi, New York. The General Treatment; by Edward F. Brush, Mount Vernon. The Use of Tartar Emetic in Diphtheria; by H. DeV. Pratt, Elmira.

Treatment of Depressions in the Skull of the Newborn; by David D. Jennings, New York. Immediate Tracheorrhaphy; by Henry C. Coe, New York. Lymphadenoma of the Uterus; by H. J. Boldt, New York. Senile Endometritis; by A. J. C. Skene, New York. Treatment of Endometritis; by Herman E. Hayd, Buffalo. Nine Years' Experience with Alexander's Operation for Shortening the Round Ligaments of the Uterus; by Paul F. Mundé, New York. Pelvic Abscess; by Walter B. Chase, Brooklyn. A Case of Hysterectomy for Retention of the Menses; by William Gardner, Montreal.

Discussion on Menstruation and its Abnormalities.—Introduction and Normal Function; by Andrew F. Currier, New York. Dysmenorrhea—its Causes and its Treatment; by Howard A. Kelly, Baltimore, Md. Profuse Menstruation; by Charles P. Noble, Philadelphia, Pa. Scanty Menstruation; by Franklin Townsend, Jr., Albany. Irregular Menstruation; by Charles A. L. Reed, Cincinnati, O., and E. W. Cushing, Boston, Mass. Menopause—Natural and Artificial; by Arthur W. Johnstone, Cincinnati, O.

Urethral Caruncles; by Edward N. Liell, New York. The Physical Causes of Sexual Debility in the Male, as Distinguished from the Psychical Causes; by F. R. Sturgis, New York. The Surgical Treatment of the Prostate Gland; by Seneca D. Powell, New York. The Fable of the Egg; by William S. Ely, Rochester. Artificial Immunity; by Henry R. Hopkins, Buffalo.

Clinical Notes on Psoriasis, with Especial Reference to its Prognosis and Treatment; by L. Duncan Bulkley, New York. Spinal Supports and Braces—the Indications for their Use—History and Modern Perfection (to be illustrated with forty lantern-slides); by A. M. Phelps, New York. Histology and Pathology of the Spinal Cord (illustrated with lantern-slides); by Wm. C. Krauss, Buffalo.

Discussion on Abdominal Surgery.—Disputed Points in the Treatment of Pelvic Surgery; by Joseph Price, Philadelphia, Pa. Influences Affecting the Results of Abdominal Operations; by J. F. W. Ross, Toronto, Canada. Hemorrhage after Abdominal Section: its Place in Statistics; by A. H. Buckmaster, New York. Cysts of the Epigastrium; by Dudley P. Allen, Cleveland, O. The Technique of the Abdominal Incision; Methods of its Closure and its Subsequent Management; by W. W. Potter, Buffalo. Operative Procedure for the Relief of Obstruction of the Common Duct; by W. E. B. Davis, Birmingham, Ala. Two Cholecystotomies for Gall-stones with Recovery, with Remarks on Operative Methods based upon Five Cases; by William Wotkyns Seymour, Troy. Gall-stones, the Exciting Cause of Malignant Disease; by Rufus B. Hall, Cincinnati, O. Appendicitis; by Charles McBurney, New York. An Analysis of 150 Personally Observed Cases of Appendicitis; by George Ryerson Fowler, Brooklyn. A Conservative View of the Treatment of Appendicitis; by William S. Tremain, Buffalo. Some Observations Relative to the Treatment of Suppurative Appendicitis, with Report of Cases; by Willis G. Macdonald, Albany. Palpation of the Vermiform Appendix; by G. M. Edebohl, New York. The Inch and a Half Incision, and Week and a Half Confinement in Appendicitis; by Robert T. Morris, New York. Report of a Case of Post-peritoneal Abscess from Duodenal Ulcer, with Presentation of Specimen; by L. S. Pilcher, Brooklyn. Intestinal Perforation in Strangulated Hernia; by William B. DeGarmo, New York. Remarks on the After-treatment of Abdominal Section; by Carlton C. Frederick, Buffalo. The Unexpected as Sometimes Observed in Abdominal Surgery; by A. Vander Veer, Albany.

Recent Methods of Gastrostomy for Stricture of the Esophagus; by Willy Meyer, New York. The Influence of Physiological Rest on Prolapse of the Rectum; by Joseph D. Bryant, New York. A Contribution to the Subject of Excision of the Larynx; by Charles A. Powers, New York. Observations on 118 Cases of Cancer of the Breast, with Especial Reference to its Radical Cure by Operation; by William T. Bull, New York. The Treatment of Hernia (supplement to paper read last year); by Alexander Dallas, New York. Some Cases of Brain-Surgery; by Herman Mynter, Buffalo. The Needlessness of a Mydriatic in Adjusting Glasses to the Eye; by D. B. St. John Roosa, New York. The Action of Scopolamin on the Eye; by Thomas R. Pooley, New York. The Treatment of Nasal Hemorrhage; by John O. Roe, Rochester. Report of a Case of Injury to the Cauda Equina; by Hermon C. Gordinier, Troy.

The Treatment and Prevention of Epilepsy in the Young; by Graeme M. Hammond, New York. The Practical Workings of the Law for the Care of the Insane; by Carlos F. Macdonald, New York. Lunatics

in Public Places; by Wallace J. Herriman, Rochester. The Subfrontal Gyre (Broca's Convolution) in Man and Apes; by Burt G. Wilbur, Ithaca. Akromegaly; by Floyd S. Crego, Buffalo. Report of a Case of Akromegaly, with the Exhibition of the Subject; by Frederick Remington, Rochester. Uremic Hemiplegia; by Reynolds W. Wilcox, New York. Glycosuria; by W. B. Vanderpoel, New York.

Dr. S. Guttman, editor of the *Deutsche medicinische Wochenschrift*, died on December 21st at Berlin as the result of a virulent attack of influenza, at the age of fifty-four years. The post-mortem examination disclosed the existence of an adherent pericardium, and sclerosis of the aorta and coronary arteries. In addition to his editorial labors Guttman was an able clinician and contributed generously to medical literature. He was collaborator with Leyden of the collective investigation into the influenza-epidemic of 1889-90, made at the instance of the Berlin Society for Internal Medicine.

Dr. Richard C. Norris has been elected physician in charge of the Preston Retreat, in succession to Dr. Joseph Price, who had resigned. Dr. Norris was graduated from the Medical Department of the University of Pennsylvania in 1887, and was at once elected a resident physician in the Philadelphia Hospital. He has for a number of years been an instructor in Obstetrics in the University of Pennsylvania, and is also one of the editors of the *Annals of Gynecology and Pediatrics*.

International Sanitary Congress.—The President of the United States has appointed Dr. E. O. Shakespeare, of Philadelphia, Dr. Stephen Smith, of New York, and Dr. P. H. Bailhache, of the United States Marine-Hospital Service, delegates to represent the United States at the International Sanitary Congress, to be held in Paris on January 24th.

A Four-years' Course at Jefferson Medical College.—At a meeting of the Faculty of Jefferson Medical College, held on January 8, 1894, it was unanimously resolved to institute a compulsory four-years' course with the session of 1895-96.

The Lehigh Valley Medical Association will hold its Sixth Winter Conversational Meeting at the Eagle Hotel, Bethlehem, Pa., on Thursday, January 25, 1894, at 10 o'clock A.M.

BOOKS AND PAMPHLETS RECEIVED.

Traitement du Pied Bot Varus Equin par l'Ablation de la Plupart des Os du Tarse. Par Le Dr. Just Lucas-Championnière. Extrait du Journal de Médecine et de Chirurgie Pratiques, 1893.

De l'Emploi des Essences et Surtout de l'Essence de Cannelle ou Cinnamol comme Topique en Chirurgie. Par Le Dr. Just Lucas-Championnière. Extrait de Journal du Médecine et de Chirurgie Pratiques, 1893.

Are Coccidia Found in Cancer? By Joseph McFarland, M.D. Reprinted from the University Medical Magazine, 1893.

Sulla Lussazione Volontaria dell'Anca, con un Nuovo Caso. Del Dott. Davide Giordano. Milano: Tip. Pietro Agnelli, 1893.

Acute Ulcerative Endocarditis: A Brief Résumé of the Pathology of Eight Cases. By Ludwig Hektoen, M.D. Reprinted from the Journal of the American Medical Association, 1893.